2021-2022 Homelessness Health Services Framework

A Framework for Enabling Care

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Land Acknowledgement

We acknowledge that our work takes place on the traditional territory of many nations including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee and the Wendat peoples and is now home to many diverse First Nations, Inuit and Métis peoples. We also acknowledge that Toronto is covered by Treaty 13 signed with the Mississaugas of the Credit, and the Williams Treaty signed with multiple Mississaugas and Chippewa bands.

Foreword

This work was only made possible with collaboration and partnership across different sectors to support people who are homeless to access to health services. These partnerships include those who composed the Steering Committee and lead multiple work streams: Community Health Centres (CHCs), health and homelessness sector service providers, Toronto Shelter Network, Toronto Drop-in Network, Violence Against Women (VAW) sector representatives, the City of Toronto (Shelter, Support, and Housing Administration and The Works at Toronto Public Health) and Ontario Health Toronto. Special thanks to Parkdale Queen West CHC and Inner City Health Associates for their leadership and ensuring this work continues.

Indigenous service providers have been continuously serving Indigenous and non-Indigenous community members and those experiencing homelessness in parallel throughout this process, using innovative and responsive approaches that meet the distinct needs of the Indigenous community. Engagement with Indigenous health and homelessness partners is ongoing to identify distinct approaches that recognize the principles of reconciliation and self-determination, as well as where opportunities for collaboration and integration into existing frameworks make sense.

Introduction

This strategic framework coordinates existing tools and resources, leverages new and existing partnerships, and outlines an approach to coordinated implementation of health services across the homelessness service system. It is accompanied by an implementation plan that outlines how the framework will be operationalized with a focus on coordinated assessment of health needs, stabilizing clients with on-site health supports, and making connections to permanent community health supports.

Background

2017

In May 2017, a Shelter Health Services Advisory Committee was established with membership from the Toronto Central Local Health Integration Network (TC LHIN), Central East LHIN (CE LHIN), City of Toronto, health service providers, and shelter operators. The Advisory Committee was formed to develop a coordinated approach to

health services delivery for shelter clients to improve access to services, health equity, client experiences and system sustainability.

Guiding the work of the Shelter Health Services Advisory Committee was *A Partnership for a Healthier Toronto*, an agreement signed by the City of Toronto and the TC LHIN in November 2017. The Partnership defines strategic and working relationships, and identifies mutual priorities to improve outcomes for residents of Toronto.

2018/2019

In 2018, the Advisory Committee released *A Framework for Coordinated Health Services for Shelter Clients*, which established the common foundational elements to include in local service delivery models. The Framework was accompanied by a *Planning Guide* to support health service providers and shelter operators jointly design and implement coordinated health service delivery models tailored to the profile and service needs of a particular shelter's clients.

In 2019, Toronto Central LHIN (TC LHIN) changed to Home and Community Care Support Services (HCCSS) and aspects of strategic health system planning and implementation merged into the functions of Ontario Health Toronto Region. In the context of these major structural changes, resources to support the implementation of the framework were limited.

2020

With the rise of the COVID-19 pandemic in 2020, a new priority emerged in supporting people in shelters through outbreak management and vaccination efforts. Through Ontario Health's Toronto Region's Homelessness COVID-19 Working Group, three key health service work streams were identified as critical to supporting people who are experiencing homelessness:

- Primary Care & Clinical Services (including psychiatry)
- Mental Health Case Management
- Harm Reduction (Overdose Prevention, Safer Supply, & Peer Support)

A renewed sense of urgency around understanding the types of supports that were needed, and embedding those supports was highlighted. During this time, Inner City Health Associates received expanded base-funding to provide primary care and clinical services (including psychiatry) within shelters funded or operated by the City of Toronto. In addition, the Ministry of Health and Long-Term Care (MOHLTC) made investments to support people experiencing homelessness during the pandemic, including isolation space with embedded clinical, harm reduction and peer supports. The City of Toronto also committed emergency COVID-19 funding to embed harm reduction supports and services in other key shelters and shelter hotels to address the substantial increase in overdose deaths at the time.

Through partnerships between the Parkdale Queen West Community Health Centre (CHC), The Neighbourhood Group Community Services (TNG), University Health Network, Inner City Health Associates, and the City of Toronto, the following programs were operationalized:

A. **Recovery and Isolation Site**: A bedded site to provide isolation support for people experiencing homelessness that test positive for COVID-19, are unable to isolate elsewhere, and require support. The program provides an integrated model of care that provides onsite services include clinical, harm reduction (HR), and peer supports. The program is pet- and family-friendly, and children/infants can remain with their parents on-site.
B. **Enhanced Shelter Support Program (ESSP):** Clinical and population health community programs that provide interdisciplinary episodic and transitional primary care and nursing support, substance use, clinical care, vaccination support and in-situ isolation support for individuals in encampments and 10 large shelter hotels which composes over 2250 (approximately 30% of shelter system).
C. **Integrated Prevention and Harm Reduction (iPHARE) Initiative**: A multi-pronged effort by the City and community partners to address overdose deaths in Toronto's shelter system through embedded harm reduction supports at key shelter locations, including specialized harm reduction staff, peer-based supports, outreach, intensive mental health case management and on-site supervised consumption services.

In addition, the following structures were also implemented during the pandemic to support this work:

Toronto Region Homelessness/Shelter Working Group was established by Ontario Health Toronto in collaboration with community providers, CHCs, shelter providers, Indigenous partners, hospitals, and SSHA. Work streams were developed in three key areas to support people who are homelessness: Primary Care and Clinical Services, Harm Reduction, and Mental Health and Case Management.

Shelter and Group Congregate Testing Table was established by Ontario Health Toronto where community health partners (including CHCs and ICHA) and hospital partners, SSHA, regional partners, shelter operators, Indigenous partners, OHT Leads, and TPH met to discuss strategies to most effectively provide COVID-19 testing and isolation supports to individuals within the shelter system. Prior to the establishment of the Citywide Joint Operations Table for vaccination, this table was leveraged as a place to plan shelter vaccinations as well.

Lastly, in 2020, the **COVID-19 Interim Shelter Recovery Strategy** was generated through a process co-convened by SSHA and United Way, and led by a task force of leaders in the homelessness service system. It included input from service users and people with lived experience, health partners, and frontline staff. The advice of the Task Force identified the importance of leveraging the momentum of the collaborative partnerships established during the pandemic to ensure recovery efforts include implementation of a health services framework.

The context of the pandemic revealed gaps and priority areas within the system spearheaded the need for a revised framework. Additionally, new and existing partnerships along with funding to support programming enabled a revised approach for system planning and collaboration.

2021/2022

In 2021, Ontario Health Toronto and the City of Toronto continued their previous partnership agreement from two perspectives:

- The City as the designated service manager for housing and homelessness services
- Ontario Health Toronto as the planner and funder of local health care services.

A revised steering committee was established to reinvigorate the previous framework with a new lens for key priorities and incorporation of pandemic learning to support people who are experiencing homelessness. Key partnerships were identified to support the Steering Committee and Parkdale Queen West CHC, followed later by Inner City Health Associates supported the City and Ontario Health with shared leadership of this work. Three working groups were established to support and operationalize the identified streams of health services (Primary Care and Clinical Services, Mental Health Case Management & Harm Reduction).

In 2021, the iPHARE Intiative was expanded to provide embedded harm reduction supports across 23 shelters, respites and shelter hotels. COVID-19 supports were also transitioned to provide mobile harm reduction support (MOVID), providing shelter operators with supports to build sustainable harm reduction practices and support people in shelters with in-situ self-isolation and peer-based harm reduction supports. This equipped providers with the tools they needed to support shelter clients to isolate in place and avoid disruptions to care; and helped to ensure capacity could be preserved in the limited isolation spaces available. This will enable current and future IPAC and inflection control practices for influenza planning and other infectious diseases.

In 2022, the MOHLTC supported the continuation of one-time COVID-19 funding to support the COVID-19 response and recovery efforts with an emphasis on supporting wind down and a sustainable plan for ongoing supports within existing structures. The City's emergency COVID-19 response in shelters was also extended, ensuring uninterrupted operation of the embedded harm reduction supports established through the iPHARE initiative to the end of 2022. Planning through this framework and the lessons learned from COVID-19 will enable sustainable supports required for this population.

Vision

The vision for this framework is to reduce barriers and ensure equitable access to health services for people who are homeless and support people to transition to housing

with a sustained attachment to health services. Our aim is to work towards improved health outcomes for people experiencing homelessness, built on a foundation of seamless collaboration between health and homelessness service providers.

Values

During the initial drafting of the framework in 2018, there was extensive engagement with the community and service providers that helped establish the following values that guide the work of this revised framework:

- Equity focused – Take into consideration that there is a disproportionate number of racialized people within the homelessness setting, especially Black and Indigenous people
- Justice – People experiencing homelessness are treated fairly
- Human Rights – People experiencing homelessness are entitled to human rights and freedoms and access to housing
- Respect – People experiencing homelessness are accepted as they are
- Empowerment – People experiencing homelessness have a voice; they have autonomy and self-determination
- Equitable Access – People experiencing homelessness have the opportunity to access services that meet their needs
- Person-Centered – Services are designed to address the individual needs of each person experiencing homelessness.
- Collaboration – People experiencing homelessness, health services, social services and housing providers work together to address client needs
- Innovation – New and creative approaches of service delivery for people experiencing homelessness are developed and implemented based on best practices and emerging approaches

Principles

The following principles and assumptions guide both the planning and delivery of high-quality health and homelessness services, and the working relationships between partners. These principles have been extracted from the initial framework and are based on extensive engagement:

1. Provide the right health services to people, in the right place and at the right time, while recognizing that shelters & transitional programs are for emergency and temporary accommodation.
2. Design services based on people's needs; involve service users in the process.
3. Work closely with Indigenous partners while respecting their right to self-determination and respecting the work that is already underway
4. Recognize, value, and integrate with work of people who are employed in peer roles
5. Adopt a low barrier lens when planning services.

6. Approach the work from a Housing First lens.
7. Build capacity of clients to access community-based health services and provide supports that foster independence and empowerment.
8. Develop a system-wide response and be locally responsive to addressing the social determinants of health.
9. Start small and grow.
10. Adopt a common language.
11. Ensure services are data driven and evaluated.
12. Build on the strengths and expertise of stakeholders.
13. Develop a coordinated, seamless approach within the City of Toronto

Objectives of the Framework

1. Ensure people who are experiencing homelessness have a connection to required health services within the three streams (Harm Reduction, Primary Care and Mental Health Case Management) regardless of where they are sheltered
2. Leverage existing resources to connect homelessness service providers to health providers within the three streams where needed
3. Identify gaps in services, resources, and partnerships
4. Provide an implementation plan, building off pandemic learning, for the sustainable model of the framework, including articulation of any resources required for operationalization.

COVID-19 Pandemic Response and Learnings

As highlighted in the Interim Shelter Recovery Strategy report, COVID-19 has accelerated collaborative problem solving between the health and shelter systems and shown that partners in both systems have the ability to work together to develop quick, creative responses to meet fluctuating needs. The collaboration that has taken place during the pandemic has also highlighted existing areas for improvement in how people experiencing homelessness receive care.

The unprecedented response mobilized by community partners supported the activation of more than 40 new shelter locations to provide physical distancing. This movement of programs and people at a rapid pace meant that people who were being moved to hotels and other sites for physical distancing required coordinated access to the necessary health services at these locations. The system has responded by adding mobile service teams, more flexible service responses, and innovative oversight and leadership models.

Some of the learning from new partnerships included:

- Relationship building and leveraging existing partnerships was key to ensuring any work was achievable;
- Leaning further into culturally competent care and partnerships supported culturally safe practices; and

- Flexible approaches to interventions (e.g., offering mobile and embedded health supports, peer ambassadors) can better meet the needs of more people

In addition, mobile outreach and low-barrier access, as well as peer-to-peer support remained a key principle to reach those within the homelessness sector as well as those who were sleeping rough and in encampments. Please see Appendix A for further details on COVID learnings related to the Recovery Site and MOVID Team. Peer workers supporting vaccination efforts enabled Toronto to have one of the top vaccine rates for this population compared to other areas in the province. Without the efforts of mobile teams, this population would not have had the same accessibility to testing, vaccination, or other health services.

These were amongst the key learnings that the Framework and associated work streams supporting this framework will consider in planning approaches. The focus on culturally sensitive practices and partnerships, peer driven approaches, in-situ planning, embedded and mobile practices will remain at the forefront for system planning and implementation to support unsheltered populations.

Meeting Crisis with Opportunity: Reimagining Toronto's Shelter System highlights some of the impacts of COVID-19 on the system and the people who use it. The reality of needing additional access to health services helped to prompt the reinvigoration of the framework.

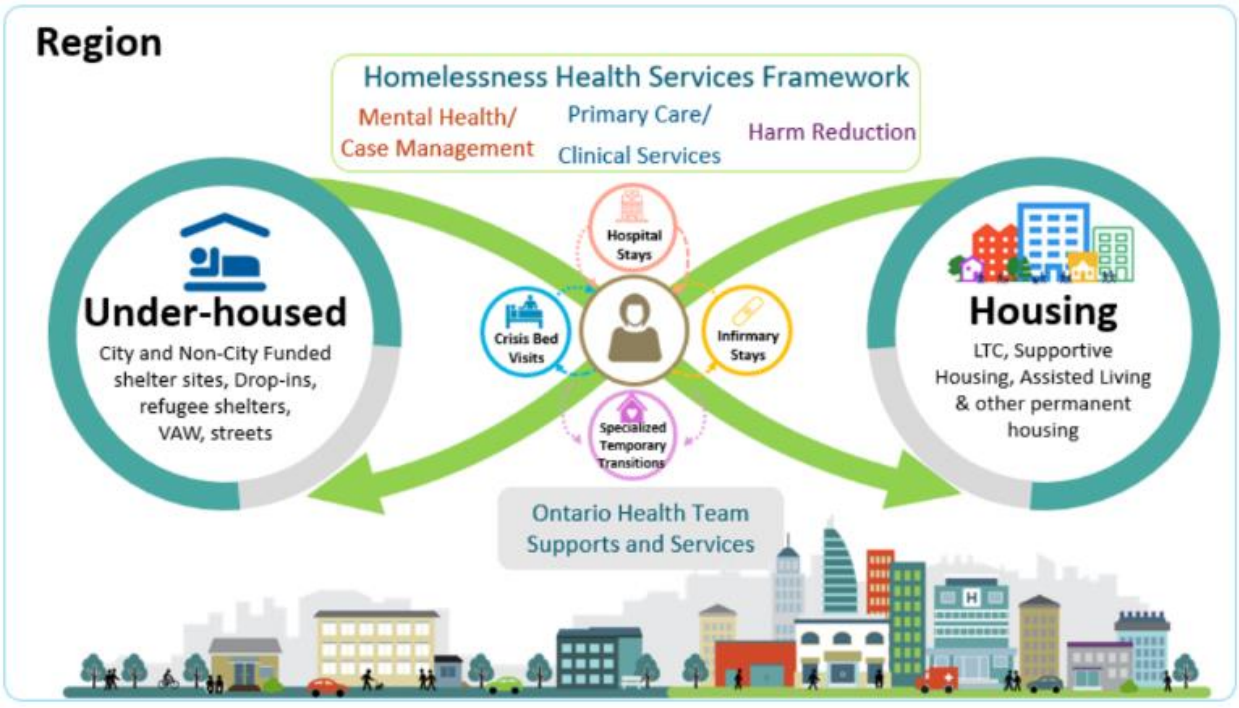
The COVID-19 pandemic had a disproportionate impact on low income and racialized communities. The recent Street Needs Assessment has shown that Indigenous, Black and other racialized people are overrepresented within homeless populations, which further emphasized a need for tailored support during the pandemic and has also informed this framework.

The Framework

The Model

The Homelessness Health Services Framework has been established with service users positioned at the center and will be supported by the three health service streams along their care continuum. The framework ensures people who are experiencing homelessness can access health services and sustain that access as they transition towards more permanent housing. Regardless of transitions (Infirmary, hospital stays, crisis beds and/or specialized temporary transitions) and inclusive of acquiring permanent housing, this model supports access to these health services and seamless transition of supports throughout a client's journey within Toronto. This model enables an assessment of the continuity of services at client and site level to plan for service access as required. The Framework also recognizes the unique interaction between these supports and the planned integration with associated Ontario Health Teams

recognizing that there is overlap between the strategies being implemented by OHTs and this framework. OHTs will continue to play an essential role in providing health supports for clients that become housed.



Work Streams

The framework brings together resources across three streams of health services: primary care (including psychiatry), harm reduction, and mental health case management. During the development of the framework, each stream worked with operational partners to identify service gaps and develop approaches to service delivery. Detailed information about the implementation of the framework across each stream of service will be made available upon the release of the Homelessness Health Services Framework Implementation Plan.

Primary Care and Clinical Services Work Stream

(Co-led by PQW CHC and ICHA)

ICHA's wide ranging specialized health services include primary care, mental health, population health, palliative care, pediatric and specialized medical services with comprehensive family health team and addictions hubs, hospital-community coordinating programs and a virtual care program that will supplement direct clinical care to provide full week-day coverage across all locations. ICHA's clinical services complement the mental health case management and harm reduction supports provided by health sector partners, ensuring consistent standards and equitable access to health care for the homeless population across all regions of Toronto.

As ICHA continues to expand and deepen its services in every region/neighbourhood of Toronto, its partnerships with Toronto Academic Health Science Network hospital

partners for service coordination, credentialing, staffing and planning both within and regionally across OHTs will deliver on the difficult promise of health system integration for Toronto's homeless population. ICHA's integrated clinical systems model will also fully complement the mental health case management and harm reduction supports provided by health sector partners as part of the comprehensive Shelter Health Services Framework ensuring consistent standards and equitable access to health care for the homeless population across all regions of Toronto.

Harm Reduction Work Stream

(Co-led by PQW CHC and The Works)

TPH provides programs and services to reduce drug related harm for people who use drugs through its program *The Works.* The Works plays an integral role in reducing drug use related harms in Toronto by taking leadership in the area of harm reduction, providing critical resources and capacity building supports for a network of harm reduction provider agencies across the City. In addition to its direct services provided at TPH, The Works manages a harm reduction supply distribution program for the City, provides mobile harm reduction and street outreach services, offers harm reduction and overdose prevention and response training, and coordinates the release of drug alerts and advisories.

The Works' leadership in this work stream, in partnership with several community harm reduction partners agencies, including Parkdale Queen West CHC and TNG, as well as South Riverdale, Regent Park and LAMP CHCs, Street Health and Sherbourne Health, has simultaneously supported rapid implementation in response to the escalation of overdoses and overdose deaths in Toronto shelters, and longer-term visioning and strategic planning.

Through this work stream the *10 Point Plan: A Guidance Document for Harm Reduction in Shelter Programs* was developed. The 10 Point Plan is guided by harm reduction best practices and promising practices, as well as learnings from the extensive and rich history of harm reduction in the City of Toronto. It also incorporates learnings from the shelter hotel site harm reduction and overdose assessments and the extensive outreach work done at these and other shelter programs in 2020 and 2021. It aligns with the Toronto Shelter Standards and 24-Hour Respite Standards, and directly informed the 2021 Harm Reduction Directive released to further expand and integrate harm reduction both as an approach and specific practices across all sheltering sites, while providing a plan for the design and implementation of successful, innovative and responsive shelter-based harm reduction programs.

Mental Health Case Management Work Stream

(Co-led by TNSS and The Access Point)

In August 2020, feedback from a meeting with case management and homeless service providers identified that access to mental health case management for people who are homeless was insufficient. Mental health case management providers did not have additional capacity to meet rapidly growing needs under the context of the COVID-19 pandemic environment. In September 2020, the City of Toronto expanded the M-DOT

program to quickly increase access to mental health case management at Physical Distancing Hotel locations across the city. Capacity management efforts in central access systems, that have historically reduced waitlists and wait times, were no longer sufficient to respond to changes driven by COVID-19.

Given this context and the renewed homelessness health services framework, this work stream was leveraged to look at long-term, sustainable options to increase access to mental health case management for people who are homeless and provide recommendations about service model and referral pathways.

More specifically, the mental health and case management work stream was tasked with recommending ways to make more mental health case management service available to homeless individuals directly at shelter and drop-in sites. The work stream convened a stakeholder table of mental health case management and homeless service providers to complete a current state analysis of service need/demand, capacity and flow, referral pathways and models of service in the mental health case management sector.

Baseline data was collected from The Toronto Mental Health and Addictions Access Point and directly from homeless mental health case management providers. The workstream to date has created a snapshot of demand and intake capacity, estimated the gap in current service, assessed referral pathway outcomes, and made recommendations about where investment is needed and the elements of an effective service model.

The work stream will continue to refine and update the model to remain current with updated information about needs and capacity, as well as to consider pandemic learnings. In addition, as the next phase of this workstream approaches, this workstream will work to implement:

- Longer term streamlined referral pathways to support shelter and drop--in access to service.
- Support Case Management access during transition points along the continuum of care, inclusive of the point at which individuals access sustainable housing.

Coordinated Access to Housing with Supports

A coordinated access system is a systems-level approach for addressing homelessness that provides a consistent way to assess, prioritize and connect people to housing and supports.

Toronto's implementation of a Coordinated Access system balances service user experience and the need for data for system-level decision making by using a Common Assessment Tool that supports a progressive engagement approach to providing people with services based on their needs. The Service Triage, Assessment, and

Referral Support (STARS) tool has been developed through extensive, collaborative user generated input with frontline staff, service providers and service users, and supports a trauma-informed, person centred approach to service delivery.

The STARS tool and Coordinated Access system allows us to assess client health needs, identify opportunities to connect clients with health services on site or in the community, and identifies transitions where connections to health services may be disrupted if clear processes are not in place. The tools that comprise this framework enable communication between intake staff, case workers, follow up workers, and health service providers to ensure people maintain connections to health services. This process will continue to be reviewed to ensure alignment with the objectives of the Framework and sustained attachment to services under the three work streams.

Homelessness Health Services Framework for Indigenous Clients and Service Providers

Indigenous homelessness and health service providers have been engaged in the development of the framework. In particular, Anishnawbe Health and the Toronto Indigenous Community Advisory Board have been involved in outlining existing processes and resources for connecting Indigenous people experiencing homelessness to health services.

The purpose of this ongoing engagement has been to better understand whether and how Indigenous providers would like to align this framework with existing services and resources for Indigenous clients, and to work together to support Indigenous clients who receive services from non-Indigenous homelessness and health service providers. For example, ICHA's Indigenous Health program staffed by 5 Indigenous physicians provides critical outreach care for Indigenous clients and families across the City of Toronto including primary care, psychiatry and pediatrics.

Parallel engagement with Indigenous health and homelessness partners is ongoing to identify distinct approaches that recognize the principles of reconciliation and self-

determination, as well as where opportunities for collaboration and integration into existing frameworks make sense.

Key Partners

As we implement the Framework, partners have varying roles to play as well as shared responsibilities to leverage current resources and supports. By defining clear roles and responsibilities, there are fewer gaps and increased ability to identify areas of sustainability and effective, streamlined implementation of the framework.

Ontario Health Teams

This framework and the associated supports are embedded within the context of Ontario Health Teams (OHTs) supporting these settings. OHTs are agencies created by the Government of Ontario with a mandate to connect and coordinate the province's health care system in ways that have not been done before. OHTs oversee health care delivery across the province, which includes ensuring front-line providers and other health professionals have the tools and information they need to deliver the best possible care within their communities. This also means simplifying the current system and connecting and coordinating its many complex parts in new and innovative ways. This involves keeping a close eye on how the health system is performing and providing evidence-based standards and improvements to address any gaps.

OHTs integrate service delivery and work together as teams to ensure coordinated care for people experiencing homelessness. The framework seeks to weave all the different strategies across OHTs to ensure access for this population continues to be a priority and that services are available that meet their needs.

Inner City Health Associates

Inner City Health Associates (ICHA) has provided clinical care to people experiencing homelessness across all regions of Toronto since 2006. ICHA's more than 200 providers within 8 clinical divisions provide specialized transitional health care for the homeless across primary care, mental health, population health and sub-specialized medicine in over 70 clinical sites in shelters, drop-ins and street outreach programs. ICHA's clinical care is provided in close integrated intersectoral partnerships with the homeless sector, housing, community health and acute care partners to optimize continuity, coordination and effectiveness of care. ICHA's outreach services bring primary care, psychiatry and palliative medicine to patients in shelters and drop-ins. The aim is to assist patients with their health & psychosocial needs and to help them navigate the social services & health system in order to transition to long-term care with a family physician in the community.

The Access Point

The Toronto Mental Health and Addictions Access Point, referred to as The Access Point, is a centralized point where people can apply for individual mental health and addictions support services and supportive housing. The Access Point provides coordinated access to a number of services within the large network of service providers through one application and intake assessment process.

Through The Access Point, people can access individual support services, including intensive case management and assertive community treatment teams (ACTT), and supportive housing opportunities.

Community Health Centres

Community Health Centres (CHCs) are non-profit organizations that provide primary health and health promotion programs for individuals, families and communities to strengthen their capacity to take more responsibility for their health and wellbeing. They provide education and advice on helping individuals and families access the resources they need from other community agencies. CHCs link individuals and families with support and self-help groups that offer peer education, support in coping, or are working to address conditions that affect health. They also support harm reduction initiatives in the community.

Community Harm Reduction Organizations

Harm reduction organizations in the City of Toronto that provide support to people who use substances in ways that minimize the health and social harms associated with substance use. These community agencies have service agreements in place with TPH to distribute harm reduction supplies through the Ontario Harm Reduction Distribution Program (OHRDP). Depending on the organization, they provide a mix of harm reduction services, including but not limited to, access to free harm reduction supplies, mobile or street outreach, training, programming for people who use drugs, and supervised consumption services. These services may be funded through various sources such as the province, the city, federal grants, or private/corporate donors.

Shelter, Support and Housing Administration at the City of Toronto

SSHA is responsible for managing a coordinated and effective system of shelter and homelessness services, working from Housing First and human rights approaches and with a focus on the people it serves.

Toronto's homelessness service system provides immediate, housing-focused, person-centred services for people experiencing homelessness, and consists of emergency shelters, 24-hour respite sites, 24-hour drop-ins, temporary COVID-19 response programs, street outreach services, and day-time drop-ins. The primary roles of the homelessness service system within the broader approach to community and social services for vulnerable residents are to provide:

- Safe and welcoming emergency shelter and overnight services for those in housing crisis
- Street outreach services for people staying outdoors, with a focus on establishing supportive relationships to address immediate health and safety needs and provide supports to move into shelter and housing
- Supports for people experiencing homelessness to develop a housing plan and to access housing and stabilization supports

- Navigation and referrals to appropriate community and health services

Homelessness Service Providers

Homelessness service providers include shelter and drop-in operators, street outreach programs, and a variety of other organizations and programs that work with people who are experiencing homelessness.

Violence Against Women (VAW) Sector

The Ministry of Children, Community and Social Services (MCCSS), Toronto Region, funds a system of thirty-eight organizations across Toronto to deliver a continuum of services to support survivors and their dependents who have experienced abuse. Included in this is the Violence Against Women Network, which is comprised of homelessness shelter providers.

Drop-In Sector

Drop-ins are daytime locations that offer access to a range of services which may include food, showers, laundry facilities, health services, information and referrals, and social and recreational activities. Services are provided in a welcoming, safe and non-stigmatizing environment.

Ontario Health Toronto

Ontario Health is responsible for working with health and system providers to ensure that there is as much alignment as possible across the system within Toronto.

- Engage system tables including OHTs to socialize framework
- Facilitate connections between partners
- Support funding proposals to enable care and work with providers to maximize existing resources

What Success Looks Like

Measuring the success of the framework and its implementation depends on identifying outcome statements that capture overall goals, indicators that reflect the progress of the work of each work stream, and performance measures that speak directly to the success of implementation at the shelter level. Appendix X will summarize the specific metrics aimed to support an evaluation of the framework and its implementation. Through implementation of this framework, we aim to effectively integrate health and social services in the three identified health service streams across both the homelessness service system and to support the transition to housing. With clients at the center, successful application of this framework enables health services to follow a client throughout their journey regardless of where they are sheltering and ensure sustained attachments as they transition to permanent housing. This may also include mobile services to ensure that those who are hardest to reach receive the services required. The needs and range of health support have been identified and can be seamlessly matched to the services available after leaving the homelessness system. This model integrates with local OHTs to deliver seamless, high quality, data driven care.

Appendix A:

COVID-19 Learnings (Harm Reduction)

Isolation & Recovery Site

Isolation and Recovery sites were established early in the pandemic to accommodate people experiencing homelessness who were required to isolate due to COVID-19. Substance use services were seen as integral for these sites to facilitating the ability of people who use substances to complete a period of isolation.

The Substance Use Services offered on-site included:

- Harm reduction education and distribution of harm reduction equipment (including sterile injection equipment, and safer smoking and inhalation equipment)
- Provision of cigarettes and outdoor space for physically-distanced smoking
- A managed alcohol program
- Prescription opioids and/or stimulants as treatment or as an alternative to unregulated drugs that people would buy themselves (opioid agonist treatments, safer opioid supply, stimulant medications)
- Prescription of medications to treat withdrawal from drugs or alcohol
- Services to prevent and respond to overdoses:
- An on-site overdose prevention site (a room where people can go to use substances - primarily by injection under the supervision of trained staff)
- In-room witnessing when using substances by staff when clients requested it
- Telephone or in-person check-ins when using substances when clients requested it
- Naloxone distribution to staff and clients
- On-call support for on-site care teams provided by specialist substance use physicians to consult on a range of treatment options that might assist clients in completing their COVID-19 related isolation periods on-site, while also reducing overdose risk.

The services were evaluated as part of the MARCO Project, an initiative by the MAP Centre for Urban Health Solutions, to evaluate how local efforts responding to the COVID-19 pandemic served people experiencing marginalization, and how the interventions can be improved. A full report of the evaluation is available here.
Some key findings of the evaluation relevant to the Homelessness Health Services Framework are:

- The provision of a continuum of low threshold substance use services within residential settings is possible and beneficial to clients and staff.
- Because of the availability and range of substance use services at the site, clients who use substances reported feeling safer there than other settings

- Continuity of care following discharge was a significant challenge.
- Training and resources such as the Substance Use Handbook and the availability of on-call specialist substance use physicians, allowed staff to rapidly learn new skills and develop competencies in working with people who use substances.

Mobile Harm Reduction Supports

The mobile harm reduction supports that were established and expanded during the COVID-19 pandemic, including the MOVID Program and the The Works Outreach, have provided important learning.

Although not formally evaluated, feedback has been positive and some shelter operators have inquired about how they can access MOVID to provide support for their staff and/or clients. As result, the MOVID management team has focused on providing services aimed at building capacity at site where they are providing support, allowing them to shift their support to out of a location and respond to needs a various sites, thus adapting the mobile COVID-related services to be responsive to identified harm reduction needs at shelter locations. The teams has worked on developing a service request process and has created a template for a responsive, mobile shelter harm reduction service.

Different types of support that are provided by MOVID include:

- education and training for staff on:
    - how to assess and respond to drug overdoses
    - how to use oxygen in an overdose
    - various drugs and how those drugs present in client behaviours
    - gear and equipment for safer drug use kits, and safer drug use strategies
    - how to talk to clients about their drug use without judgment, safer language for talking about drugs, trauma-informed ways to talk to people who use drugs
- support uplifting harm reduction programs and services, such as:
    - Urgent Public Health Needs Sites (a.k.a. “overdose prevention sites”)
    - Low barrier managed alcohol program, including implementation of training and protocols
- consultation about harm reduction policies, procedures and protocols, to increase operator capacity and provide lower barrier support
- coordinating care with operators to protect clients’ shelter
- facilitating debriefs after emergency events on site
- planning for client safety and wellness, from a client-led approach
- Support for clients, including:
    - substance use witnessing, or “spotting”
    - “smart shooting” workshops, and information about safer use strategies

- connection to safer opioid supply, safer stimulant supply, and opioid agonist therapy, and advocacy relating to these treatment
- support for clients isolating in situ with covid symptoms through witnessing daily dispensation of controlled substances and/or MA
- overdose response workshops for community members\
- social and recreational programming for community members
- facilitating client advisory committees
- coordinating responses to critical events (client grief and loss)

The Works has also looked at how they can pivot supports to respond to specific and emergent needs, and have been able to do so throughout the pandemic. The teams have been able to support new and relocating shelters to set up on site distribution of harm reduction supplies, including naloxone, as well as provide harm reduction and overdose prevention and response training to new and/or redeployed staff.