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Rapid Review

Supporting equitable access to health and social services for people experiencing homelessness in Ontario

Prepared for the Ontario Ministry of Health

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About

The North American Observatory on Health Systems and Policies (NAO) is a collaborative partnership of interested researchers, research organizations, governments, and health organizations promoting evidence-informed health system policy decision-making.

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List of Abbreviations

CATCH	Coordinated Access to Care for the Homeless
CHC	Community Health Centre
CTS	Consumption and Treatment Services
ED	Emergency department
ICAP	Inner City Access Program
H.O.M.E	Health Outreach Mobile Engagement
MACS	Multi Agency Community Space
MOST	Mobile Outreach Support Team
NP	Nurse Practitioner
OICH	Ottawa Inner City Health
PEACE	Peer Education and Connection Through Empowerment
PEACH	Palliative Education and Care for the Homeless
PEH	People or persons experiencing homelessness
REACH	Regional Essential Access to Connected Healthcare

Executive Summary

People experiencing homelessness (PEH), including those who are vulnerably housed, often face challenges accessing health and social supports due to stigma and exclusion. This rapid review highlights promising interventions to increase access to health and social services for PEH in Ontario. We synthesize the evidence about these interventions that seek to promote access to health and social services for homeless populations in the province, with attention to enablers and barriers to collaborative cross-sectoral approaches.

We conducted a rapid literature review and consulted with local experts, including clinical and administrative leads of relevant organizations, to uncover and explore the enablers and barriers to supports for PEH to access to health and social services. We searched three academic databases and conducted both broad and targeted website searches to identify interventions within three entry points: 1) non-urgent/primary health; 2) social services; and 3) urgent-self referral. We extracted information on program features, funding, and partnerships, along with evidence of impacts on health, and access to health and/or social services for PEH. Where possible and in specific areas of interest, we met with local experts.

Our review uncovered a diversity of initiatives, mostly in non-urgent/primary healthcare and social services entry points, with few programs in the urgent self-referral (e.g., through hospitals) entry point. Most initiatives involve formal partnerships with one or more organizations (most including a combination of both health and housing/social sector organizations); and impact health and emergency department (ED) diversion by providing low-barrier care where PEH are, grounded in trauma-informed and harm reduction philosophies, and offering harm reduction services via interdisciplinary teams. Cross-cutting challenges across these points relate to funding. Experts described a general lack of core operational and sustainable funding resulting in program insecurity and difficulties in longer-term program and organizational planning, diverting funds within organizations to keep critical programs operational, and challenges with hiring and staff retention.

Multiple promising initiatives are helping to fill gaps in health and social supports for PEH. The COVID-19 pandemic increased temporary funding and political support for investment in these programs, but long-term supportive housing alongside sustained investment and rigorous evaluation of low-barrier, culturally safe primary and social care programs are urgently needed.

Introduction & Background

People experiencing homelessness (PEH) – those having no fixed address, including those who are vulnerably housed – those living in unstable or insecure housing, often face challenges accessing health and social supports due to stigma and exclusion. Accordingly, there are higher rates of unmet need and emergency department (ED) use among PEH, which in part relates to broader barriers accessing essential health and social services (Campbell et al., 2015; Kushel et al., 2002; O'Carroll & Wainwright, 2019). Although the PEH population across the province is highly heterogenous, they face distinct health challenges relative to the general population, including higher rates of morbidity and mortality as a result of the negative synergies between concurrent physical illnesses, mental health issues, and substance use. These health challenges are exacerbated by inconsistent access to primary care and social support services (Luchenski et al., 2022).

A variety of approaches have been taken to address the health and social needs of PEH, such as providing primary care in "non-traditional" settings, including the community (Davies & Wood, 2018; Saragosa et al., 2022). Preventive interventions within hospital settings (e.g., care coordination/system navigation, outreach, and social welfare assistance) have shown improved psychosocial health outcomes, improved ongoing access to the healthcare system, and addressed wider health and social care needs due to ongoing barriers to accessing primary care (Saragosa et al., 2022). From a system level, preventative approaches have been found to improve healthcare cost/cost-effectiveness outcomes (Luchenski et al., 2022). Outside of traditional and non-traditional healthcare settings, initiatives that provide housing (either contingent on abstinence from alcohol or drug use or with no such conditions) are associated with decreased levels of substance abuse, reductions in relapse from periods of substance abstinence, unnecessary health services utilization, and increased housing tenure (Fitzpatrick-Lewis et al., 2011).

Broadly, homelessness interventions benefit from collaborative, equity- and trauma-informed approaches, that coordinate healthcare providers and community organizations. Other common elements across models involve bringing care to areas where PEH are located, empathetic staff, multidisciplinary teams, continuity-of-care to facilitate trust between program staff and PEH, and the provision of a range of healthcare services (Institute of Medicine [US] Committee on Health Care for Homeless People, 1988). In practice, there are systemic failures that can contribute to or exacerbate underlying causes and systemic inequalities contributing to homelessness, such as barriers to social services, poor transitions out of public institutions (i.e., foster care or prison), and gaps in community and health services (Gaetz & Dej, 2017). Existing services are limited by fragmentation between services, inhibiting their ability to adequately support PEH throughout the continuum of available health and social services to gain housing or support for substance abuse issues (Fitzpatrick-Lewis et al., 2011; Hwang et al., 2005).

Given the heterogeneity of Ontario's homeless population, a range of policy options are required to pursue sustained transitions to housing to achieve greater societal integration and improved health and wellbeing. The United States (US) is one of the earliest adopters of a national approach to understanding and addressing the health and social care needs of PEH. National attention and large-scale strategies emerged in the US in the 1980s—the most significant being the creation of the Health Care for the

Homeless program (1983).[1] Local agencies that had historically provided services to PEH could no longer cope with the growth of PEH; accordingly, Health Care for the Homeless was developed to help up to 50 of the largest US cities meet the healthcare needs of local homeless populations. These cities forged a coalition of healthcare professionals and institutions, volunteer organizations, and shelter providers, among other participants, to develop a model to meet the healthcare needs of local PEH, improve their access to services, and a strategy for the continuation of services after initial funding ends. Emerging from a grant from the Health Care for the Homeless program, the Boston Health Care for the Homeless Program (BHCHP), launched in 1985, is now considered the gold standard for programs that provide comprehensive healthcare and social services to PEH. The program has demonstrated cost-effectiveness and has been scaled up to become a national model of providing comprehensive, compassionate healthcare to PEH (Boston Health Care for the Homeless Program, 2023). In the Canadian context, policy attention toward the health and social care needs of PEH has moved at a slower pace, yet local strategies do exist.

This rapid review uncovers promising interventions that aim to increase access to health and social services for PEH in Ontario. We synthesize the evidence for these interventions that seek to promote access[2] to health and social services for homeless populations in Ontario, with attention to policy innovations related to collaborative cross-sectoral approaches. We examine the continuum of policy initiatives across a range of potential entry points for health and social services, considering: 1) non-urgent health (e.g., primary care or community organizations, where a primary care provider is the first point of contact); 2) social services (e.g., housing or social benefits, without an explicit focus on healthcare service delivery); and 3) urgent self-referral (e.g., at EDs for either acute conditions or psychiatric assistance. We hope these findings inform the future adoption of effective approaches and provide a foundation for related future cost-benefit analyses.

[1] Health Care for the Homeless was a grant-based program co-funded by the Robert Wood Johnson Foundation and Pew Memorial Trust, which in turn spurred the passing of the Stewart B. McKinney *Homeless Assistance Act* (1987), which represented the first nationwide program to address healthcare problems facing PEH (Institute of Medicine (US) Committee on Health Care for Homeless People, 1988).

[2] By “access” we refer to the ease with which people can obtain care when and where they need it. Improving access requires the reduction of physical, financial, cultural, and other systemic barriers. It also requires continuity-of-care (seamless transitions in care within and between services) and equity (responsiveness to patient needs, and consideration of social and cultural determinants of health) (Li et al., 2020).

Methods

We conducted a rapid literature review and consulted with local experts to uncover and explore promising innovations that support access to health and social services for PEH in a selection of Ontario municipalities.

First, we searched three databases in August 2023 (PubMed, Ovid Medline, and ProQuest) to identify interventions within the three target entry points—1) non-urgent/primary health and social needs; 2) social services; and 3) urgent self-referral—that have proven successful in increasing access to health and/or social services for PEH. We employed defined search criteria and a combination of Medical Subject Heading (MeSH) terms and text words; filters were added for publication year (2016–present) and the English language. The results of the search were imported into Covidence, a web-based management software, to remove duplicates and screen articles. Articles were included if they were in English, published between 2016–present, focused on connecting PEH with health and/or social services, described an intervention, program, or initiative aimed at increasing access for PEH in Ontario, included impacts or outcomes of the initiative, and available publicly or through the University of Toronto Library. We excluded commentaries, articles that did not mention an explicit initiative to improve access to health and/or social services, and articles that primarily focused on COVID-19 pandemic measures, infection control, or minimizing virus transmission.

We then searched websites of key organizations (e.g., Homeless Hub, Wellesley Institute) and relied on experts and project partners to identify additional initiatives. We also used Google to search for additional information about initiatives that were potentially excluded from the academic search. The same inclusion criteria from the academic search were applied. See **Appendix A** for a detailed methodology, including search strategy terms.

Local experts, including clinicians, and administrative and executive members of organizations, were contacted to gather additional information about select initiatives (“cases”). These cases were selected if they had an actual or potential impact on reducing ED visits and to ensure diverse examples of initiatives and locations. Indigenous led/focused initiatives were excluded. Case summaries were prepared and sent to local experts for review and validation where possible. All experts (n=11 individuals from 7 different organizations) were asked about where gaps existed—i.e., to gain insight on how interventions were implemented (including challenges and barriers) and how they were/are evaluated.

Limitations

Our search does not represent a comprehensive catalogue of all initiatives in Ontario. Rather, we identify a variety of initiatives that showcase the breadth of approaches across the province to support health and social care needs of PEH.

The academic literature search was limited by publication date (2016–2023) and language (English), and we did not perform a critical appraisal. Though limited by publication date, this was unlikely to significantly affect our findings given there is a considerable delay between when initiatives are in operation and when related articles are published. Both academic and grey literature were excluded if there was insufficient information describing a specific program/intervention, if there was no mention

of health- or health system-related outcomes, and if the initiative did not appear to address both health and social care.

Interventions that specifically responded to the COVID-19 pandemic were omitted. Overall, there was a lack of publicly available information and data related to programs targeting the health and social needs of PEH (e.g., funding, outcomes, performance, etc.). Local experts were consulted where possible to provide additional details about specific initiatives, and encouraged to reflect on broader organizational and systems level challenges.

Although we cast a wide net around promising interventions to improve access to health and social services for PEH in Ontario, we acknowledge that our findings may not be generalizable to all programs supporting PEH groups. For example, our review included some programs supporting Indigenous peoples; however, our research team does not include Indigenous researchers with established partnerships with communities, so we were not able to include Indigenous-focused initiatives in our case studies. Further research in partnership with Indigenous and specific ethno-racial community organizations would complement the findings from this report.

Analytic Overview

Our review of the academic and grey literature identified a broad range of promising programs across the three entry points of interest. Given our aim of capturing the overall existing landscape, the description of our findings includes a mix of individual initiatives/programs (approximately 50) as well as some overarching organizations leading these programs. We make note of this distinction to emphasize that in many cases, even more important than the individual initiatives is how these programs integrate into broader healthcare systems to make meaningful impacts.

The first two entry points (non-urgent/primary health and social services) yielded a wide range of initiatives and programs, whereas only a few examples were found for the third entry point (urgent self-referral). Identified programs were from several communities across Ontario (both urban and rural), though most were in major city centres (i.e., Toronto and Ottawa). Many of the initiatives involve collaboration or partnership with one or more organizations (most including a combination of both health and housing/social services), are low-barrier to increase service access, involve interdisciplinary teams, are trauma-informed, adopt a harm reduction philosophy, and offer harm reduction services.

Below we provide an overview of the organizations and initiatives found for each of the three entry points and a synthesis of the challenges, facilitators, and reported impacts on health and health systems. Further details are presented in **Appendix B**.

Entry point and service provision

TABLE 1. Examples of initiatives and programs, by entry point

Entry Point	Examples from review
Entry Point 1: Non-urgent/ primary health care	• **Integrated and co-located health and social services**: Multi Agency Community Space (MACS); Community and Service Hub ("The Hub"); Dymon Health Clinic; Inner City Access Program (ICAP); Nurse-led HIV PrEP and Safer Opioid Supply Program; The Trailer and Supervised Consumption sites (OICH); YMCA Elm Centre and Women's College Hospital outpatient collaboration; Niiwin Wendaanimak Four Winds Wellness Program; Special care units (OICH); Enhanced supportive housing (OICH); Targeted Engagement and Diversion (TED) Program • **Addictions treatment**: Kwaw Kii Win Centre Managed Alcohol Program; Managed opioid program; Gambling Addiction Program • **Mobile and street health**: Essex Community Health Centre (WeCHC) on Wheels (Mobile Clinic); Hamilton's Social Medicine Response Team (HAMSMaRT); Health Outreach Mobile Engagement (H.O.M.E.) Program; Palliative Education and Care for the Homeless (PEACH) Program; Regional Essential Access to Connected Healthcare (REACH) Niagara, StreetHealth • **Other collaboratives**: Respect RX Pharmacy Pharmasave; West End Quality Improvement Collaboration
Entry Point 2: Social care and services	• **Outreach:** Mobile Outreach Support Team (MOST); The Vulnerable Persons Outreach Project (VPOP); Housing Outreach Program Collaboration (HOP-C); Housing Outreach Program Collaboration-North (HOP-C-North); Makwa Patrol, Kenora; Street Outreach, London

	• **Peer-support and education**: The Supporting Transitions and Recovery Learning Centre (STAR); Peer Education and Connection Through Empowerment (PEACE); Reintegration Centre, Toronto • **Supportive and transitional housing:**[2] John Howard Society – Rita Thompson Building; Bridges to Housing (B2H); YMCA Sprott House; Big Island Model (BIM); Cambridge STEP Home Collaborative; Resting space; Mino Kaanjigoowin (MK) program at Na-Me-Res (Native Men's Residence)
Entry Point 3: Urgent/self-referral	• **Post-discharge navigation and case management**: Coordinated Access To Care from Hospital for the Homeless (CATCH),[1] Navigator Programme • **Permanent supportive housing with comprehensive primary and social care**: UHN Social Medicine Housing Initiative; Highly supportive housing, London Cares[1]

[1] Further details also provided in the "Mini Case Study" section.

* We identified several articles (>10) that described various initiatives/programs modelled on the *Housing First* approach to improving access to health and social services for PEH. Given the large volume of articles, and that these programs are already well-studied, we do not describe each program in detail (some examples are discussed under Entry Point 2 below). The full list of initiatives identified through our literature search is available in Appendix B.

Entry Point 1: Non-urgent/primary health care

We identified several initiatives that aim to improve access to health and social care for PEH through non-urgent/primary healthcare settings or teams. The types of initiatives ranged from clinical outreach programs to community hubs, outlined above in **Table 1**.

There were several examples of integrated and co-located health and social services. Community health and social "hubs" are characterized by the integration and/or co-location of health and social service organizations and supports in one place. These hubs are coordinated by partners to support homeless and unsheltered individuals who are unable to access limited shelter space, providing a wide range of services (ACCKWA, 2023; Regional HIV/AIDS Connection, 2023). More examples of co-located and integrated services were identified outside of a hub model. For example, the *Dymon Health Clinic*—offered by Ottawa Inner City Health (OICH) and the Ottawa Mission—uniquely provides both primary and dental care services, as well as other specialist services that often require referrals (e.g., vascular surgery, ophthalmology) (Ottawa Inner City Health Inc., n.d.; The Ottawa Mission, 2019). More common were examples of health services offered in shelters and in conjunction with other social supports. For example, a key feature of *the Inner City Access program (ICAP*) in Toronto was the co-location of a primary care team alongside supporting housing services offered by the shelter system to provide low-barrier support to marginally housed people with severe and persistent mental health and/or addiction issues (Millward, 2018; Pauley et al., 2016).

We identified several organizations that offer health services via mobile clinics or street health units. These clinics and teams assist PEH by providing them with low-barrier care in accessible locations. A wide range of services were reported, including primary and acute care, mental health and addictions care, referrals to other health services, picking up prescriptions, accompanying individuals to their specialist appointments, and more (Buchanan et al., 2023; Inner City Health Associates, 2023a; Kovacs Group Inc., 2022; REACH Niagara, 2021, 2022; Robinson et al., 2023; Steadman, 2021); as well as arranging meals (Buchanan et al., 2023; Inner City Health Associates, 2023a; Robinson et al., 2023; Steadman, 2021). Distinct from outreach services identified in entry point 2, these initiatives primarily provide healthcare, are mainly comprised of health professionals, and led by a healthcare organization.

Other collaboratives include the *West End Quality Improvement Collaboration*—a partnership of six community health centres (CHCs) whose collective goal is broadly to increase the efficiency and effectiveness of service delivery to better serve the most marginalized populations (e.g., PEH) in west Toronto (Callaghan et al., 2019); and *RespectRx,* an independent community pharmacy in Ottawa that serves inner-city populations and has partnered with OICH, allowing it to apply various subsidies and funding arrangements to cover supplies and medications for individuals in need of diabetic supplies (Respect RX Pharmacy, n.d.).

Entry Point 2: Social services

Social services initiatives aiming to improve access to health and social care for PEH occurred on a variety of fronts, including community outreach programs, peer support and education programs, and housing-related programs.

Outreach programs involve teams who visit locations frequently attended by their target population and in other accessible locations to provide social services and basic needs (e.g., food, water, information about and referrals to community resources, etc.) and, in some cases, health services (Campbell, 2019; CBC News, 2019; Janzer, 2019). For example, the *Housing Outreach Program Collaboration* (HOP-C) in Toronto provides critical timely interventions comprised of transitional outreach-based case management, group and individual mental health interventions, and peer support to facilitate the transition of youth out of homelessness, with a focus on preventing reoccurrence (Kidd et al., 2019; Lund et al., 2022). Another is the *Mobile Outreach Support Team* (MOST) in the Windsor-Essex region, which includes a team of specialists (social worker, outreach worker, and personal support worker) using a fully accessible van (Campbell, 2019; CBC News, 2019; Janzer, 2019). Another initiative—the *Vulnerable Persons Outreach Project* (VPOP)—is operated by the Durham police department (in collaboration with other local partners), aiming to support the needs of vulnerable individuals by identifying frequent police service users and individuals at risk of becoming involved with the law (e.g., PEH with mental health challenges), and proactively connecting with them before they experience a crisis (Martin et al., 2023; The Oshawa Express, 2018). Outreach (and mobile units described above) was especially critical during the COVID-19 pandemic to locate and provide care to dispersed persons who faced compounding challenges and needs (Bond, 2023; personal communication).

Specific programs focus on offering peer-led support and education. These initiatives include group classes and workshops taught by people with lived experience in addition to health service processionals (Durbin et al., 2021; Kahan et al., 2018, 2020; Khan et al., 2020). Based on client needs, peer support workers may also make referrals to a continuum of supports and other service agencies, such as housing, addiction, harm reduction, and employment services (McLuhan et al., 2023).

The most abundant subcategory of social service-entry point initiatives identified through our search were those that prioritized supportive and/or transitional housing programs. Of these initiatives, several were rooted in Housing First: "[A] recovery-oriented approach to ending homelessness that centers on quickly moving people experiencing homelessness into independent and permanent housing and then providing additional supports and services as needed" (Canadian Observatory on Homelessness, n.d.). For example, the Bridges to Housing (B2H) program was developed by Toronto's Shelter and Support Services (TSSS) and a multidisciplinary primary healthcare team, with funding from the Ministry of Health, as part of Ontario's poverty reduction strategy (Lamanna et al., 2020). This program, which ran

as a two-year demonstration project (2016–2017) to provide care for PEH with Intellectual and Developmental Disabilities (IDD), sought to facilitate immediate access to housing of participant's choice via rent supplements, as well as to healthcare services and other social supports (Lamanna et al., 2020; Reid et al., 2021). Another program rooted in Housing First is the long-standing *Mino Kaanjigoowin (MK) program at Na-Me-Res (Native Men's Residence*), which has been in operation since 2008 and aims to assist members (mainly members of the Indigenous community) with securing stable housing, and to provide culturally safe case management, primary care, and mental care services (Firestone et al., 2021).

Some of the identified supportive and transitional housing programs did not appear to have an explicit connection to the Housing First approach. For instance, the *Rita Thompson* building in Ottawa, operated by the John Howard Society (JHS) in collaboration with Ottawa Inner City Health and one of Canada's foremost mental healthcare hospitals—the Royal Ottawa—has a primary focus on supportive housing for people experiencing long-term homelessness (Din et al., 2018; John Howard Society of Ottawa, n.d.). The program provides clients with 24/7 access to case workers from JHS and offers on-site medical services provided by Ottawa Inner City Health (OICH), with the goal of reducing tenant involvement in the criminal justice system and diverting clients away from hospitals (Din et al., 2018; John Howard Society of Ottawa, n.d.). Another example, Toronto's *YMCA Sprott* House offers a transitional housing program designed specifically to meet the needs of LGBTQ2S youth (Abramovich & Kimura, 2021; Miller, n.d.; YMCA Greater Toronto, n.d.).

Entry Point 3 – Urgent self-referral

The final entry point—urgent self-referral—refers to health and social care access via urgent services, such as hospital emergency rooms. The fewest specific initiatives/programs aimed at PEH were identified in the reviewed literature for this entry point (most based in Toronto).

Of these initiatives, two are focused on post-discharge care navigation and case management—*CATCH* and the *Navigator Programme*, which connect PEH with post-discharge needs to improve post-hospital health outcomes and reduce preventative hospital visits (Inner City Health Associates, 2023b, 2023b; Lamanna et al., 2018; Reid, Brown, et al., 2022; Reid et al., 2021; Reid, Mason, et al., 2022; Stergiopoulos et al., 2017, 2018; Liu et al., 2022). The other two initiatives—*University Health Network's* (UHN) *Social Medicine Housing Initiative* and London Care's *Highly Supportive Housing*—were recently implemented in late 2023 to provide supportive housing and comprehensive health and social care to marginalized individuals and high utilizers of acute care services (Berenbaum, 2019; Khandor et al., 2011; London Cares, 2023a). Distinct from the housing-related initiative represented by entry point 2, these programs work with hospital partners to divert PEH from inpatient or ED visits. Refer to our mini case studies below and **Appendix B** for a more in-depth description of these programs.

Target population

Given the heterogeneity of this population, local experts underscored the importance of developing targeted but flexible programs able to respond to evolving and emerging needs. This was exemplified by tailoring programs to certain PEH subgroups, based on factors such as health status/illness such as diabetes care (OICH/*Respect Rx* clinic), palliative care (*PEACH*), severe or persistent mental health and/or substance use and addictions (*ICAP, MOST, ACCESS open minds; REACH Niagara*), gender identity and sexual orientation (e.g., special care units at OICH, *PEACE, and YMCA Sprott House*), age (e.g., *YMCA*

Sprott House, HOP-C North, and ACCESS Open Minds), and location (e.g., mobile/street clinics). People who use substances were targeted through harm reduction and safe supply programs, supervised consumption sites (e.g., *The Trailer,* OICH*, and REACH Niagara*), and substance therapy programs (e.g., *Managed Opioid Program*). As many housing-related initiatives may require abstinence or other prerequisites, London Cares targets individuals who are highest acuity and "restricted" from other services and supports. There are also a few programs specifically aimed to support members of urban Indigenous communities, including two programs operated in Toronto: *Niiwin Wendaanimak Four Winds Wellness Program* (Firestone et al., 2019; Parkdale Queen West Community Health Centre, 2023), and the Mino Kaanjigoowin (MK) program at Na-Me-Res (Firestone, Syrette, et al., 2021).

Experts also discussed changes over time in terms of the needs, size, and diversity of the populations they serve. For example, increased illicit drug use and an increased toxic drug supply has caused some programs and organizations to focus specifically on substance-use related supports (e.g., *HO.M.E.* program in London). Experts from *REACH Niagara*, noted that a large proportion of its clients are strictly reliant on their Safer Supply program, and therefore a forthcoming loss of grant funding for *Safer Supply* could compromise adherence, resulting in a return to street substance use and severe risk of overdose. Moreover, application reviews for new supervised consumption sites have been halted, posing a significant service gap and opportunity (personal communication, 2024). As well, many outreach teams are increasingly serving individuals living in encampments. People living in encampments face significant challenges to health, security, and wellbeing, with many encampments being treated with heavy surveillance and policing (Farha & Schwann, 2020).

Another important note from experts was that when attempting to develop and/or implement tailored programs, the local context should be carefully considered. For example, a program successfully implemented in Toronto may or may not find success in smaller communities, and vice-versa. However, this consideration should not undermine important lessons that can be learned from other municipalities in terms of potentially helpful program design features, including where to obtain funding and defining roles and responsibilities of staff and interdisciplinary care team members (clinical and non-clinical).

Funding

Where found, funding for these initiatives and their respective organizations included multiple sources, such as government, non-government or charitable groups, and grants. Government funds are provided via health insurance (e.g., Ministry of Health) (Parker, 2020) and through specialty funds and programs at the federal, provincial, and municipal levels. Examples of specialty funds and programs include the Local Poverty Reduction Fund to evaluate program impacts (Ontario, 2017; Toombs et al., 2021), Enabling Accessibility Fund (London Cares, n.d.), and the Toronto Urban Health Fund (StreetHealth, 2023). In 2021, *REACH Niagara* also began receiving additional funding from the Ontario government through an Alternative Funding Plan partnership with the Shelter Health Network in an effort to help support collaboration with community partners to ultimately improve access to health and social services for marginalized communities and PEH (REACH Niagara, 2021). In London, several housing-related initiatives, such as those operated by London Cares, receive funding from the City of London as projects fall under the umbrella of the *Health & Homeless Whole of Community System Response* in London (London Cares, 2023a).

The COVID-19 pandemic increased temporary funding and political support for investment in some of these programs. For example, at the pandemic's outset, *PEACH* received funding to establish a health navigator role with the aim of providing social care through addressing housing, income, food security, and access to healthcare needs (Robinson et al., 2022). Experts from OICH noted their community outreach approach had significantly changed due to the pandemic, expanding to serve more people in the community via a COVID-19 testing van and vaccination program. For other cases, redeployment and diverted funds resulted in reduced programming, as was the case for the *Niiwin Wendaanimak Four Winds Wellness Program*.

Experts highlighted an overall lack of resources and core operational and sustainable funding, which resulted in program insecurity and difficulties in long-term program and organizational planning, diversion of funds within organizations to keep critical programs operational, and challenges with hiring and staff retention (described further below). Inadequate funding also resulted in initiatives to end, such as the *WeCHC on Wheels* mobile clinic in Windsor, and OICH's women's special program, which was identified as leaving a significant and concerning gap to address (personal communication, 2023). Funding limitations were also seen to have impacted service delivery. In Niagara, for example, since outreach funding is meant to support PEH, supports cease once individuals become housed. This leaves individuals disconnected and often results in people ending up back on the streets (personal communication, 2023).

Different funding models for health and social sectors were also noted to pose challenges for collaborative efforts. As described by a local expert, the lack of funding from a partnering agency in the social sector hindered the full potential and expansion of the initiative. In another example, a CHC would like to support an initiative that requires full-time nurse practitioners (NPs) to provide primary care; however, the CHC lacks resources (nurses) to contribute. The expert also said that inadequately addressing any concomitant social issues makes it difficult to solve clinical issues and may worsen conditions over time. This fragmentation between sectors was also said to impact those trying to access services and that such compartmentalization compromises the ability to build trust and provide ongoing support (personal communication, 2024).

Organizations have made great efforts to increase their presence within their broader communities and stakeholders via government, media, and private relations in an effort to support programming. In fact, several of the described initiatives must also rely on philanthropic funding to support their programming administration. Several local experts also mentioned the need to constantly write grants to renew existing funding opportunities and attain new funding. Some programs draw on creative funding solutions for administrative costs, such as *REACH Niagara* that uses physician funding through the Ministry of Health for clinic services, however, this is not a sustainable approach to retaining administrative staff (personal communication, 2024).

Team composition and human resources

These initiatives are comprised of multidisciplinary and interdisciplinary teams, including physicians, nurses, mental health and community health professionals, allied health professionals, and other specialized care professionals, as well as administrators and peer workers. Within these teams, specialized community workers, NPs, and peer workers were highlighted as integral to many initiatives. An example of a specialized community worker is the health navigator role within the PEACH program.

This person is skilled in system navigation, interdisciplinary collaboration, and evaluating and meeting the social needs of their clients (Robinson et al., 2023). Peer support workers in particular have been critical to facilitating relationships and fostering a sense of belonging. Many organizations ensure staff participate in training to help better understand client needs and respond to crises, which may include trauma-informed, equity-informed, and anti-oppressive approaches to care and overdose responses.

There are great challenges to staff recruitment and retention across the province in both health and social sectors. Many experts noted that turnover and vacancy was particularly high for nurses and has detrimental effects on patients; evaluations support the need for increased human resource capacity and infrastructure (Firestone, Syrette, et al., 2021). The primary reason for turnover and vacancy relates to inadequate funding. Burnout and trauma also greatly contribute to recruitment and retention. A local expert shared that a CHC partner hiring for a nurse had to re-hire every 1–2 weeks because the candidates would be offered a significantly higher salary working elsewhere Another local expert stressed the importance and need for nurses and other frontline staff to be experienced working with these populations and have a reasonable expectation of their role; otherwise, they will continue to experience quick turnover. As noted in the *Funding* section above, retaining administrative and clerical staff remains challenging due to funding design in programs such as *REACH Niagara*. Grants ought to be available for non-frontline staff to be hired on a permanent (not contract-based) basis.

Local experts emphasized the need for competitive salaries, benefit packages, and other staff supports and many are seeking opportunities to facilitate this. Experts from *London Cares* mentioned providing individual and group counselling sessions through Thames Valley Addiction and Mental health Services to ensure staff wellness, and experts from OICH shared that plans are underway to establish a more competitive compensation and wellness plan for staff. While organizations are making efforts to attract and retain staff, one local expert highlighted the limitations encountered in a grassroots organization and that adequate supports are ultimately needed from the province, especially in the case of nurses.

Further, another expert emphasized the importance of promoting equity in hiring and recruitment processes that values lived experience. Moreover, individuals with marginalized identities, disabilities, or health conditions should not be penalized or limited for utilizing such benefits, such as the Ontario Disability Support Program (ODSP), upon employment. Importantly, it should be assumed and understood that engagement with some peer workers/persons with lived experience will be episodic, and that relapse is part of recovery (*personal communication,* 2023).

Measuring impacts and outcomes

Few programs conduct formalized and structured assessments of program performance, particularly in relation to patient (client) experience, health outcomes, and system outcomes (e.g., emergency department [ED] diversion). Some programs like *CATCH* have developed a logic model – an outline or visual depiction of the interrelationship(s) between a program's activities, resources and outcomes – to identify desired program outcomes and the necessary inputs (structures and processes) to achieve them but note that outcomes are difficult to measure; this is, in part, due to the transient nature of the PEH population, most of whom do not have a health card. Yet, there is keen interest across all programs in identifying and measuring outcomes for a number of reasons, including: to apply or reapply for funding, for scale and spread, and to drive program improvements.

Despite challenges in designing structured outcome measurement, programs do have impact, and our search identified several across initiatives that can been assessed both quantitatively and qualitatively. These impacts include broader health system-level impacts (e.g., on service utilization [number of clients served or interactions], cost reduction, ED diversion), as well as more specific patient- or client-level health impacts (e.g., on overdose prevention, disease identification and management, and client satisfaction). A summary of the impacts and outcomes are summarized below and in **Tables 2 and 3.** Methods for collecting data to measure program impacts include informal methods of feedback (e.g., client testimonials, sharing feedback and observations in staff meetings), surveys, interviews, and emergency medical record (EMR) data. Qualitative methods were commonly used to assess client satisfaction, challenges accessing care, and ongoing needs.

Data access and sharing was also reported in some cases, such as the AIDS Committee of Cambridge, Kitchener, Waterloo and Area (ACCKWA) who are provided with ED data from local hospitals to help inform up-to-date assessments; *CATCH*/Inner City Health Associates who receive City of Toronto data; *REACH Niagara*, who receives service utilization data from Telus Health and EMRs; and members of HAMSMaRT and McMaster University who collect and publish data on deaths of PEH in Hamilton to help support targeted interventions. Some programs outsource evaluation expertise by partnering with academic institutions to facilitate the design and implementation of evaluation plans and other research activities. For example, London Cares has a partnership with London Health Sciences Centre (LHSC) to implement and evaluate its highly supportive housing program, and *REACH Niagara* collaborates with a local Ontario Health Team (OHT) to design a client experience data survey (funding provided by the OHT), and will be collaborating with the McMaster School of Medicine in future research opportunities.

Health system-level impacts and outcomes

TABLE 2. Summary of health-system level impacts and outcomes of identified initiatives

Impact(s)/ Outcome(s)	Key examples
Service Utilization *(e.g., # clients served, # unique engagements, # concerns addressed, # referrals made to other providers or services)*	• **The Trailer**: Average of 228 visits per day; over 8,000 visits per month; 220 unique clients seen; over 39,000 referrals made (Ottawa Inner City Health, 2023). • **Managed Opioid Program (MOP), OICH**: During its first year (August 2017–2018) 96% of the clients it served had been successfully connected with the appropriate behavioural health services (Harris et al., 2021). • **MACS (2022/23)**: 12,595 engagements, 5,020 harm reduction interactions, 1,032 healthcare interactions, 402 housing interactions; daily average of 65 clients (ACCKWA, 2023). • **H.O.M.E. Program**: 1,059 unique clients access medical and WrapAround care services – a model of family-driven care – during its first year (approximately 30% of whom accessed H.O.M.E services more than once) (H.O.M.E Program, 2022; Kovacs Group Inc., 2022). • **Dymon Health Clinic**: From 2018 to 2019 there was a 74% increase in client consults and 579 dental-related consults and treatments (Ottawa Inner City Health Inc., n.d.; The Ottawa Mission, 2019). • **Vulnerable Persons Outreach Project (VPOP)**: In the 18-month period of program operation, the team completed 202 visits with 143 service users (Martin et al., 2023; The Oshawa Express, 2018).

	• **Bridges to Housing (B2H) program**: 12 months post-enrolment in B2H, 92% of participants were successfully housed (Reid et al., 2021). • **The Hub**: The number of visits increased by 31% from April 2023 (1,700 visits) to September 2023 (2,224 visits) (London Cares, 2023b). • **REACH**: Provided 2,560 interventions and 1,404 medical treatments in 2023. The top reasons for a visit was related to substance use and mental health (REACH Niagara, 2023a).
Cost effectiveness *(e.g., % reduced cost per patient)*	• **ICAP**: Average 60% reduction in healthcare cost per client (Pauley et al., 2016). • **TED**: Estimated healthcare cost reduction of about $521K in avoided ED visits (Zinn & Beaudoin, 2016).
ED diversion *(e.g., # individuals diverted from hospital, # hospital emergency avoidances)*	• **H.O.M.E Program**: In its first year, 1,175 non-essential ED visits by 400 unique individuals were potentially avoided; their team directly performed 18 emergency medical interventions (H.O.M.E Program, 2022; Kovacs Group Inc., 2022). • **TED**: 305 hospital diversions by emergency medical services from January–March 2023 (Ottawa Inner City Health, 2023). • **CATCH:** A "sister intervention" of the program (CATCH-ED) demonstrated a 14% reduction in ED visits (Stergiopoulos et al., 2016, 2017). • **Street Outreach, London Cares**: 63 individuals diverted from hospital in the last year and 44 individuals diverted from EMS (London Cares, 2023d).

Service utilization and referrals. Many of the identified initiatives track service utilization, such as the number of client interactions or engagements, new clients, services offered, and referrals made. These data were often found available on websites for the initiative/lead organization and in annual reports. In some cases, these data were reported as part of evaluations and supplemented in local news media.

Overall, initiatives targeting PEH report an increase in service utilization and referrals over time. Some initiatives have seen significant growth since the onset of the COVID-19 pandemic. For example, *PEACH*'s patient roster has more than doubled in size to now include over 100 individuals, thereby further contributing to efforts to reduce strain on healthcare systems (e.g., by diverting individuals who would otherwise visit EDs for such services away from hospitals) (Healthcare Excellence Canada, 2021; Steadman, 2021). Rapid increase in service use has also resulted in turning people away from services due to capacity issues. For example, between April and September 2023, individuals were turned away from Resting Space 1,674 times and from the "Hub" 53 times (London Cares, 2023b). Programs planning to engage in more rigorous program evaluation have begun collecting informal qualitative data on service utilization. *REACH Niagara* uses a formalized assessment form to develop several utilization measures, including "where would you go if *REACH* were unavailable?" to which most clients responded "nowhere."

Cost-effectiveness. Although available financial details for the identified programs were limited, we did find an evaluation exploring the cost-effectiveness of the *Inner City Access Program (ICAP)*. The assessment was performed by calculating the average cost per person before and after implementation of the program (Pauley et al., 2016). Findings showed that the cost per person was greatly reduced for both registered nurse (RN) and personal support worker (PSW) service delivery; 16-months post-

implementation saw 147 clients served at an average 60% reduction in cost per client (Pauley et al., 2016). There was a large increase in clients enrolled for services (20 to 147 by the end of the study period); notably, the authors evaluation reported that all clients would have qualified for service provision before the study implementation but had not previously enrolled due to lack of visibility of the service providers, the complexity of the referral and enrollment procedures, and difficulty accessing the services at convenient times or locations (Pauley et al., 2016). A cost analysis of the early phases of OICH's *Targeted Engagement and Diversion (TED)* program found that of 15,240 episodes of care (from 2013–2015), 1,852 were verified as being true ED diversions where care was provided in TED rather than in an ER; amounting to an estimated cost reduction of about $521,000 (Zinn & Beaudoin, 2016).

ED Diversion. A few of the identified programs were designed to help reduce the burden on hospital EDs, such as *CATCH, H.O.M.E. Program, TED*, and housing programs from *London Cares*. As described above, a cost analysis of *TED* found that 1,852 episodes of care were verified as being true ED diversions (Zinn & Beaudoin, 2016). Another analysis of *TED*'s impacts between 2013–2020 also concluded that the program had been successful at "changing the pattern of ER utilization for homeless people with substance use disorder" (Ottawa Inner City Health, 2021). An evaluation of a "sister intervention" to *CATCH,* known as *CATCH-ED*, found a 14% reduction in frequency of ED visits but, compared to routine care, brief case management did not result in significantly improved health outcomes (Stergiopoulos et al., 2016, 2017).

Other program impacts were found that may affect PEH use of hospital ERs. For example, the Kenora Makwa Patrol has "helped take pressure off police and ambulance services in the city, because people are able to call the Makwa team for support or crisis intervention" (CBC News, 2021). This was similarly described by local experts who shared that the very nature of the care provided/services offered are potentially life saving, such as wound care, harm reduction services, naloxone distribution, providing and connecting people to food, housing, and health services, and more (see also patient-level health outcomes and impacts below).

Patient-level health impacts and outcomes

TABLE 5. Summary of patient-level impacts and outcomes of identified initiatives

Impact/ Outcome	Key examples
Disease identification and management *(e.g., # screenings performed, access and use of preventive medication)*	• The West End Quality Improvement Collaboration: Improved cancer screening rates after one year (Callaghan et al., 2019). • **Nurse led HIV PrEP Prevention program**: Expanded access to pre-exposure prophylactics • **RespectRX**: Subsidies and funding arrangements to help cover the cost of supplies and medications for diabetes.
Substance use and harm reduction *(e.g., % reduced or stopped substance use, # overdoses responded to, # overdoses prevented)*	• **Managed Opioid Program (MOP),** OICH: 45% stopped using non-prescribed opioids after 12 months enrolment (Harris et al., 2021). • The Trailer: Reverses 1.2 overdoses daily (Shepherds of Good Hope, n.d.-a). • **TED program**: From 2017–2020 there was a nearly 11-fold increase in overdose instances in which naloxone was administered (from 9 to 97) (personal communication, 2023).

	• **Street Outreach, London Cares**: responded to 84 instances of overdose and distributed 2,080 naloxone kits in the last year (London Cares, 2023d). • **H.O.M.E. Program**: 95% of survey respondents reported increased use of harm reduction strategies; 12 overdose responses were conducted between Jan 2021 and Jan 2022 (Kovacs Group Inc., 2022)
Client experiences, satisfaction and other impacts *(e.g., quality of life, satisfaction, barriers and facilitators to care, housing status, other self-reported measures)*	• **Safer Supply Program, OICH**: Overall improvements in mental health for clients of the program with the average reported 'mental health score' increasing from 1.75 to 3.74 after participating in the program (Haines et al., 2022). • **H.O.M.E Program**: 100% of clients who completed the survey were comfortable accessing care through H.O.M.E and found it easier to access care because of this program; 84% of survey respondents reported feeling that they were treated respectfully by H.O.M.E. program staff; 72% reported improved well-being; and clients reported an increased sense of safety (Kovacs Group Inc., 2022). • **Reintegration Centre:** The peer-led service hub model enhanced the service encounter experience; efficiently and effectively addressed re-entry needs through the provision of basic supports and individualized service referrals (McLuhan et al., 2023).

Disease identification and management. The *West End Quality Improvement Collaboration* in Toronto evaluated the performance of the six collaborating CHCs after its first year of implementation and found that cancer screening rates had improved among the target population (i.e., marginalized individuals such as PEH) (Callaghan et al., 2019). Increased screening rates could help improve early detection of cancers, thereby reducing the number of ED visits by people with cancer symptoms appearing later on, especially among individuals who do not have easy access to a primary care provider and would therefore be more likely to seek care from an ED in such situations.

Additionally, the *Nurse-led HIV PrEP Program* (PrEP-RN) in Ottawa—a nurse-led pre-exposure prophylaxis (PrEP) program offered by OICH within a safer opioid supply (SOS) program to provide access to PrEP for people who use drugs—reported that 55% of the 43 individuals who were offered PrEP accepted, 65% of whom continued to use PrEP for at least six months (CATIE, 2022). Thus, this program demonstrated potential for being a "highly effective way to expand access to HIV prevention among people who use drugs" (CATIE, 2022), which could in turn help reduce the number of future ED visits by those in the program.

Substance use and harm reduction. Multiple initiatives evaluated their impact on substance use (e.g., reduced or stopped use) and harm reduction (including overdose prevention). For example, in 2022 an analysis of data from 478 clients of the Safer Supply Program (for which OICH is a collaborating partner) found that 70% reported decreasing their use of illicit opioids (i.e., fentanyl) (Haines et al., 2022). Another evaluation of Safer Supply from 2023 reported similar findings—74% and 78% of participants had either decreased or fully ceased their use of fentanyl and illicit stimulants respectively (Haines et al., 2023). Overdose prevention was reported in different ways, including through tracking the number of overdose responses (Kovacs Group Inc., 2022), and the number of naloxone kits distributed or administered (personal communication, 2023).

Client experiences, satisfaction and other impacts. While not the main focus of this review, impacts relating to client experiences and satisfaction were often assessed qualitatively in program evaluations (i.e., through interviews, open-ended surveys) and on websites sharing client testimonials. These evaluations often noted program implications for client/patient quality of life and satisfaction, self-reported outcomes, and barriers and facilitators to program implementation.

Evaluations of the *YMCA Sprott House* and *Peer Education and Connection Through Empowerment (PEACE)* programs both reported high levels of client satisfaction. While young members of the LGBT2QS community served by the *YMCA Sprott House*, and service users of the PEACE program expressed gratitude for the supports provided to them, both evaluations described a need for future evaluations to assess these programs' impacts on quality of life, mental health symptoms, and substance use (Abramovich & Kimura, 2021; Kahan et al., 2018, 2020). Evaluations of other programs also demonstrated impacts around client satisfaction for non-health-related areas of life. For instance, OICH's *Managed Opioid Program* was found to help improve clients' family relationships and ability to secure employment (Harris et al., 2021). Finally, a process evaluation of *Niiwn Wendaanimak Four Winds Wellness program* from 2019 concluded that since its inception in 2015, the initiative "is meeting the needs of homeless and at-risk Indigenous populations in Toronto" by facilitating access to "culturally specific Indigenous supports. . . health education, case management. . . primary care and harm reduction supports, and social recreation activities to build social connections" (Firestone et al., 2019).

Mini Case Studies

These mini-case studies were developed using information gathered from the academic and grey literature, and further enhanced through in-depth consultations with local experts (e.g., clinician directors and administrative and executive members) directly involved in the initiatives described. These case studies describe salient examples of programs/initiatives across Ontario that represent a variety of entry points (type of initiative) and where there is meaningful information on key variables of interest, including services provided, funding, health human resource distribution, program success and challenges (including implementation challenges), and approaches to measurement and evaluation. Further information about these initiatives is available in **Appendix B**.

Coordinated Access to Care for the Homeless (CATCH), Toronto

CATCH is one of the many specialized programs offered by Inner City Health Associates (ICHA) – a large health organization with over 200 collaborating physicians and nurses. Funded by the Ontario Ministry of Health, ICHA collaborates with several partners to offer a wide range of primary and mental health services to Toronto's homeless population, and prioritizes the integration of such services into the overarching health systems to maximize impact.

Objective: To assist people discharged from hospital who are experiencing homelessness and mental health and addiction problems, reducing preventable hospital visits, improving continuing of care following hospital discharge, and coordinating access to care for homeless populations who visit the EDs and inpatient units of hospitals in downtown Toronto (Inner City Health Associates, 2023b).

Partners: St. Michael's Hospital (Unity Health Toronto), Inner City Health Associates and Toronto North Support Services (now LOFT Community Services).

Key features:

- Referral-based program that assists people discharged from hospital who are experiencing homelessness and mental health or addiction problems and are not connected to services to immediately access health resources in their community.
- An adaptation of critical time intervention (CTI)[3] for a local context and received input from community partners, clients, and researchers/experts in homeless health.
- Referrals are accepted from partner hospital and health centres EDs and inpatient units (St. Michael's Hospital, St. Joseph's Health Centre, and The Centre for Addiction and Mental Health (CAMH) or from community agencies (Unity Health, 2023).
- Immediately following a referral, on-site Transitional Case Managers (TCMs) who work across hospital sites meet with patients ("clients") in the ED or inpatient unit. If not on-site, CATCH TCMs will meet with referred patients in the community within 3–5 days. Meetings determine patients' immediate needs and link them to resources in the community. TCMs also work with providers to initiate three short-term (3–6 months) services: 1) access to a short-term family physician, 2) access to a short-term psychiatrist, and 3) access to a short-term intensive case manager. CATCH team members then follow up with patients to ensure they are connected successfully to the care their need. TCMs also help patients navigate the system, link clients to legal and health care supports, financial resources, provide referrals to external housing and treatment resources, and provide counselling and support.

[3] *CTI is a model of care designed to support PEH during transitions of care, including the period of post-hospital discharge in which those experiencing mental illness are at high risk of experiencing first-episode or recurrent homelessness. CTIs involve intensive case management over a time-limited period (e.g., 6–9 months), helping patients navigate the health and social service systems and [re]establish access to longer-term community-based connections, resources, and interventions. CTI has been shown to reduce readmission, improve quality of life, reduce rates of homelessness, and is a cost-effective model of care transition* (Reid, Mason, et al., 2022).

- During the COVID-19 pandemic, their team contributed to the COVID-19 Isolation and Recovery Sites (CIRS) in response to the need for supported isolation spaces for PEH that has been evaluated (Firestone, Bayoumi, et al., 2021).
- Part of the Health Services for Individuals Experiencing Homelessness Initiative, established in April 2020, to address urgent system gaps in the homelessness sector was recently awarded with provincial government funding (Ontario, 2023).

Impact and evaluation: A logic model was developed to identify program outcomes (desired impacts) and corresponding inputs and activities to achieve these outcomes. Inputs include a combination of human resources from all involved organizations, infrastructure, medical supplies, funding, and direct pathways to client services (e.g., legal, financial, immigration, employment, and rehabilitation). Activities are organized across three domains: 1) assessments (e.g., medical assessments conducted by clinical team, needs assessment at first case management visit, and assessment for transitional care); 2) connections (referrals to client services); and 3) collaboration with program (regular clinical and case management meetings and shared care planning). Outcomes are centred on the client experience (case management and clinical outcomes), and situated across short-, medium-, and long-term timeframes. Short-term program outcomes include identifying client needs, immediate shelter support, and crisis stabilization. If seen by a clinical team, short-term clinical outcomes include health stabilization, prescription dispensing, and Ontario Disability Support Program (ODSP) assessment. Achieving short-term outcomes is necessary for medium-term case management and clinical outcomes (e.g., both income and housing stabilization, referral to long-term case management, and facilitating connections to community supports and longer-term mental health and specialized medical care as needed) and long-term case management and clinical outcomes (e.g., reduction in chronic homelessness and ED visits, and improved physical and mental health).

Ottawa Inner City Health (OICH)

OICH is a charitable organization that provides primary care, health promotion, specialist, and some tertiary care to PEH with complex health needs, severe and persistent mental illness, and/or overwhelming substance abuse. Since its inception in 2001, OICH has offered a wide range of programs rooted in an evidence-based approach in collaboration with several community partnerships.

Partners: OICH has many partners, including, but not limited to, homeless shelters and housing providers (e.g., Shepherds of Good Hope, John Howard Society), hospitals, and community health providers (Ottawa Inner City Health Inc., n.d.). Senior leaders of partner agencies are represented on their corporate board. Memorandums of Understanding (MOU) are established to ensure partnerships are based on aligned philosophies and facilitate conflict resolution—a critical feature given that nearly all of OICH's programs/initiatives (with the exception of their supervised consumption site) are offered from partner sites and delivered by three different agencies.

Funding: OICH's main source of funding is core funding from the provincial government (to support its CHC services), Community Mental Health (CMHP), Substance Abuse Program, which are blended across sites to support operations, and Consumption and Treatment Services (CTS) for supervised consumption services, which integrates on-site services from other funding streams). Additionally, OICH has several project-based funding sources to supplement the work being done and try novel approaches.

Key programs and initiatives: Special care units, enhanced supportive housing, community outreach, peer support programs, *Targeted Engagement and Diversion (TED)* program, and CTS; "The Trailer" and Safer Supply (see **Appendix B** for details).

Impact and Evaluation: Most of the evaluation plans are for individual care plans, ED diversion (elements that fit into funding priorities) (personal communication, 2023). We identified a few reports regarding some impacts of initiatives operated by, or in partnership with, OICH. For example, a qualitative study published in 2020 reported findings and reflections from individuals involved in running these initiatives, such as some of the program benefits for PEH with diabetes (Campbell et al., 2020); Safer Supply Ottawa evaluations reported interim findings of the collaboration and outcomes among its clients (Haines et al., 2022, 2023), and annual reports on the TED program reported on service use and cost-

analysis data (Ottawa Inner City Health, 2021, 2023; Zinn & Beaudoin, 2016). Local experts from OICH highlighted two key prominent challenges to program/care delivery and sustainability, including staff retention and funding.

Future Objectives: Local experts from OICH shared some key future goals, including improving data collection and management around key performance indicators, developing strategic plans, working on more competitive compensation and wellness plans for staff, and expanding programs and services around trauma-informed treatment.

Regional Essential Access to Connected Healthcare (REACH) Niagara

REACH Niagara ("*REACH*") is a non-profit charitable organization (incorporated in 2018) that consists of a comprehensive system of geographically accessible shelter-based clinics and eight mobile clinics that serve PEH in the Niagara Region (REACH Niagara, 2022, 2023b).

Objective: To reduce barriers to healthcare for marginalized populations, specifically homeless people, in Niagara.

Partners: *REACH* has a comprehensive interdisciplinary team derived from multiple community partners, including the Niagara Medical Group Family Health Team (FHT), Bridges and Quest CHCs, Community Addictions Services Niagara, Gateway Residential and Community Support Services of Niagara, and Telus Health.

Funding: *REACH* has no base funding and operates on a donation model that funds medical equipment and supplies, maintenance for the mobile clinic, and basic necessities for clients (e.g., food, water, socks, and feminine hygiene products). Family physicians are largely partners in *REACH* and receive money from the Ministry of Health, which is given to *REACH* on the basis that they handle the administration and functioning of shelter clinics and pay for the overhead costs for physicians to practice. Physicians also receive sessional rates as part of Shelter Health Hamilton (an hourly rate based on a minimum number of patients seen). TELUS Health is the primary sponsor of the Mobile Health Clinic. The Safer Supply Program was funded through a grant from Health Canada (ending March 31, 2024). *REACH* also receives a fully funded full-time peer for Safer Supply through Community Addictions Services Niagara. Two additional peers come from a partnership with Gateway Residential and Community Support Services of Niagara. Hired directly by *REACH* is an executive director, a full-time mental health and addictions counsellor, and an office administrator.

Key features:

- Services are low-barrier, and no health card or appointment is required.
- Services include ongoing primary care (including mental health care), select form assistance, connection to supports, counselling, harm reduction supplies, preventative care screening, system navigation (including transition to a permanent primary care provider), and referrals.
- Operations depend on strong community partnerships to form an interdisciplinary team of providers across its shelters and mobile clinics. Seven family physicians provide shelter-based and mobile clinic care and are involved in prescribing for Safer Supply. The Niagara Medical Group FHT provides a full-time system navigator for the mobile health clinics. Bridges and Quest CHCs provide a part-time NP who has an important role in fostering care continuity, especially via the mobile clinics.
- Guidance on clinic operations and job descriptions was derived from speaking with similar shelter-based organizations in Hamilton and Toronto.

Impact and evaluation: No formal evaluations have been conducted. However, through Telus Health, *REACH* is able to collect basic data, which they informally track using Google spreadsheets, including information about service use (e.g., interventions across different sites, number of people seen, and interventions provided). Through the formalized assessment form on the EMR, *REACH* is able to pull data including issues addressed, outcomes, forms completed (e.g., special diet and ODSP), types of referrals, and where the client would go if REACH was not available (the top answer being nowhere). *REACH* will soon (early 2024) implement a social demographic form modelled off a similar form used by St. Michael's Hospital in Toronto. Evaluating Safer Supply by *REACH* was said to be difficult because any utilization data that is collected would be done by Health Canada. Most recent estimates suggest there are 76 users of Safer Supply, representing the most complex individuals in

REACH's system. These users are strictly reliant on Safer Supply, and the completion of funding may compromise adherence resulting in a return to street substance use and severe risk of overdose.

Future directions: REACH's 2023–2026 Strategic Plan outlines five strategic directions in the areas of sustainability, governance and accountability, service delivery, partnerships, and staff and provider engagement. Each strategic direction has accompanying actions and timelines (REACH Niagara, 2023b). REACH is working closely with their Ontario Health Team (OHT) to design a client experience data survey (funding provided by the OHT) and will be collaborating with the McMaster School of Medicine on future research opportunities.

Health Outreach Mobile Engagement (H.O.M.E.) Program, London

Objective: The *Health Outreach Mobile Engagement (H.O.M.E)* program operates a mobile health clinic that aims to provide accessible, barrier-free, non-judgmental healthcare to PEH, those insecurely housed, or rostered clients of the London InterCommunity Health Centre.

Partners: A collaborative effort between five key community partners: the Canadian Mental Health Association's (CMHA) Thames Valley Addiction and Mental Health Services, London Cares Homeless Response Services, the London InterCommunity Health Centre, the Middlesex-London Paramedic Service, and the Regional HIV/AIDS Connection.

Funding: Financial support for *H.O.M.E* is provided mainly by the Government of Canada's Substance Use and Addictions Program, Ontario Health West, and the Ontario Ministry of Health. Local experts noted that the ministry's funding ends on March 31, 2024, at which point the program may be discontinued if the additional funding proposals that have been submitted by program administrators are unsuccessful (personal communication, 2024).

Key features:

- Key target population is those individuals who are "sleeping rough" and thus have very little stability or structural supports, one or multiple chronic health condition(s), and are difficult to reach with services offered by the brick-and-mortar CHCs.
- The program was developed in response to three critical issues: 1) opioid poisoning and overdoses; 2) the COVID-19 pandemic; and 3) homelessness and precarious housing.
- The program supports the Health and Homelessness Whole of Community System Response in London.
- Mobile clinic (staffed by two EMS, an RN, and an NP) travels across the city providing both initial and follow-up care five days per week and (two days services are offered from a converted bus; three from an SUV).
- The focus is to offer accessible, barrier-free, non-judgmental healthcare. Since the program deals with a large volume of repeat clients, emphasis is placed on building rapport with the clientele, as well as fostering a non-punitive culture (e.g., clients do not get banned, no security guards), in order to encourage clients to seek follow-up care.
- Other services include navigating the health and social service systems, harm reduction support, infectious disease testing, housing support, basic needs, and referrals to agencies and community service partners.

Impact and evaluation: A program evaluation report of *H.O.M.E* during its first year (January 2021–2022) as published in March 2022. Key outcomes outlined in this report included service use (e.g., number of clients served), real or potential ED diversions (e.g., non-essential ED visits prevented, overdose responses), and client satisfaction (e.g., self-reported client well-being) (Kovacs Group Inc., 2022). Additionally, local experts described anecdotal evidence of client satisfaction, citing the high rate of service use and number of repeat clients despite not being able to advertise the program—suggesting that the program's positive impact(s) are being shared via word of mouth (personal communication, 2024). The evaluation also included a collaborative partner survey to gain insight on what has gone well, what could be done differently, and what difference the program has made on how partners work together. Responses from the survey described high staff/worker satisfaction, outlining several metrics, including improvements in service coordination and a high level of inter-provider communication (Kovacs Group Inc., 2022). To further emphasize this point, *H.O.M.E* was the recipient of the 2021 Pillar Community Collaboration Award.

H.O.M.E. has since created a business plan that details two proposed operational models. The first (Phase 1: Sustainable Model) outlines the basics required to maintain current program operations, while the second (Phase 2: Scaled Model) outlines the requirements to meet the increased demand for its services.

London Cares

London Cares provides outreach and housing-related supports and services to help individuals experiencing chronic and persistent homelessness. Their work is grounded in Housing First principles and they are the first Housing First organization in London (London Cares, n.d.). The organization is inclusive to serve all PEH regardless of gender, sexual orientation, culture, or age, and focus particularly on individuals of higher acuity.

Partners: *London Cares* has a multitude of partners and they collaborate on various initiatives in the region. Partners and collaborators include but are not limited to: CMHA Thames Valley Addiction and Mental Health Services, London InterCommunity Health Centre, Middlesex-London Paramedic Service, Regional HIV/AIDS Connection, Ontario Aboriginal HIV/AIDS Strategy (OAHAS), City of London, the Sisters of St. Joseph, Voyago Health, and many more.

Funding: Majority of funding for programs is provided by the City of London. They also receive funding through partnership with London Health Sciences Centre (LHSC) and grants.

Key programs and initiatives: Street outreach, Resting Space, Housing Stability Program, Highly Supportive Housing, H.O.M.E., and the Hub (see Appendix B for more details).

Impact and evaluation: London Cares has begun evaluations for its highly supportive housing program in partnership with LHSC. Early success stories have begun to emerge, including reduced ED visits, reduced overdoses, and increased family connections.

Multi Agency Community Space (MACS), Cambridge

Objective: A collaborative drop-in hub to support homeless unsheltered individuals in Cambridge who are unable to access limited shelter space.

Partners: The AIDS Committee of Cambridge, Kitchener, Waterloo and Area (ACCKWA; lead), Cambridge Self Help Food Bank, Langs CHC, Lutherwood Housing Services, Stonehedge Therapeutic Community, Canadian Mental Health Association, Sanguen Health Centre (health van), and the Region of Waterloo.

Key features:

- The only full-time collaboration supporting homeless unsheltered individuals in Cambridge who are unable to access limited shelter space.
- Supports include for basic needs, mental health, the housing PATHS list for affordable and supportive housing, addictions treatment, primary healthcare, harm reduction, encampment outreach, overdose response, some nutrition support, and support for individuals with acquired traumatic brain injury.
- The majority of staff and volunteer team at ACCKWA identify as peers.
- The Region of Waterloo entered into a two-year lease agreement with ACCKWA at a lease rate of $1 at the Region of Waterloo's Public health and Social Services building at 150 Main Street (Coxson, 2021).

Funding: Funders include the AIDS Bureau, the Region of Waterloo Housing, and the City of Cambridge.

Impact and evaluation: There are roughly 250 unsheltered individuals who are seen at a regular basis at *MACS*, with annual engagements between 12,000-16,000. Service volume, interactions, and naloxone distribution are tracked, some of which are required for HIV and Hepatitis C programming for the Ministry of Health. Some data from local EDs can be requested and shared, such as emergency room use, opioid deaths, and some costs associated with different forms of usage. Some of these data have been shared to support programming (e.g., CTS application).

Future directions:

- Expansion of HIV and PrEP clinics and eviction prevention services in Cambridge.
- CTS application (currently paused)

UHN Social Medicine Housing Initiative (Parkdale Housing & Health), Toronto

The Social Medicine Housing Initiative is one of the many programs offered by the University Health Network (UHN) Gattuso Centre for Social Medicine – a network of several collaborating research and teaching hospitals.

Objective: To better address the social determinants of health and improve health outcomes for residents living with complex health and social, while also reducing utilization of acute hospital care.

Partners: UHN (lead), City of Toronto, United Way, and community-led organizations. A framework for the program was established through a Memorandum of Understanding in 2019 between the City of Toronto, United Way, and UHN that outlines the initiative's purpose, priority areas for action and collaboration, and roles and responsibilities of each party (Social Medicine Initiative Memorandum of Understanding Between University Health Network And City of Toronto, 2019).

Key features:

- Anticipated start in fall of 2024.
- Supportive housing model with a comprehensive approach that provides integrated health and social services onsite to address the social determinants of health.
- Services facilitated by community health workers (CHWs) and NPs.
- Residents will be linked with community partners to access additional community-based supports as another form of social prescribing.
- Future tenants will be referred by the UHN who will be cross-referenced with Coordinated Access. Tenants must also meet at least one of the following criteria to be prioritized for housing: 1) experience homelessness for at least six months over the past year; or 2) experience recurrent homelessness over the past three years, with a cumulative duration of at least 18 months. Priority will be given to individuals who recurrently utilize UHN clinics and/or EDs, and who fall under equity-deserving and prioritizing groups (City of Toronto, 2023).

Impact and evaluation:
Evaluations will begin as tenants move into the housing site to determine the impact of the housing model on the residents and the broader healthcare system. Success will be indicated by improved health outcomes and patient-reported outcome/experience measures (PROMS/PREMS) for residents, connection of residents to community services, and reduced acute care utilization.

Conclusions

Our review uncovered a diversity of initiatives, mostly in non-urgent/primary healthcare and social services entry points, with a few programs in the urgent self-referral entry point (e.g., through hospitals). Most of the initiatives involve formal partnerships with one or more organizations (most including a combination of both health and housing/social sector organizations), and impact health and ED diversion by providing low-barrier care where people are, involving interdisciplinary teams, rooted in trauma-and-equity informed and harm reduction philosophies, and offering harm reduction services. Cross-cutting challenges were faced with funding and human resources, and the growing challenge of homelessness faced across the province and country.

Important lessons can be gleaned from the literature and case studies around the necessary conditions that will yield intended impacts. Our review highlights the following considerations:

- **Program features to be low-barrier, adaptable, and responsive:** Initiatives must meet immediate needs of PEH, recognize that these needs cross multiple dimensions of the human experience (mental health, housing, finance, legal, social, and psychosocial, etc.), and address underlying risk factors. Thoughtful interventions that are interdisciplinary, highly integrated, and involve community are important. For example, bringing services into the shelter system (harm reduction, primary care, and peer support), was a strategy employed during the COVID-19 pandemic to minimize risk of COVID-19 transmission that also addressed a previous challenge in connecting PEH to comprehensive services they need. Moreover, interventions must be amendable to adaptation given changing contexts and circumstances, and the emergence of new needs among new populations. This requires structural supports that enable organizations and providers to respond to crises, and nimble organizational and funding models.

- **Capacity for collaboration, integration, and care coordination needs to be enhanced:** Experts highlighted the importance of integrative collaboration and partnerships across service streams and relevant orders of government. Across health and social service sectors, there are competing needs and mandates driven by factors such as available funding and accountability structures. No one entity will embed all the necessary supports needed for communities of PEH being served. Sectors must operate in an ecosystem guided by principles of partnership and common goals; specifically, that improving and sustaining health outcomes for PEH necessitate strong social services (e.g., housing support). Informational sharing and coordination continue to be a challenge across health and social sectors. Enhancing cross-sectoral capacity may also better support care continuity and further reduce siloed care interventions.

- **Community and relationship building:** COVID-19 put a spotlight on the disparities experienced by PEH in accessing both healthcare and social support. The pandemic also exacerbated the conditions contributing to homelessness, including a lack of social support. While health is an important need, what emerged and took precedence as a greater need during the COVID-19 pandemic was social care elements among clients. As a result, important adaptations were made during the COVID-19 pandemic to strengthen support for social care needs involving building relationships with community members. Particularly during crises (e.g., substance use), the availability of community and/or opportunities for PEH to be supported to build community becomes important. Peer support workers have become critical in facilitating relationships and

fostering a sense of belonging and community among PEH. Peer support workers represent not just people with lived experience (providers), but those who currently use services who can also serve as advocates. PEH are more likely to respond to peer support workers during a crisis if there is a previously developed relationship built on trust.

- **Human resource support:** Across health and social services, workers are responding to crises (i.e., housing and overdose), critical events, experiences of trauma, and threats of violence. Structural support for staff delivering community-based services needs to be embedded to account for challenging work conditions and trauma that may contribute to burnout or gaps in human resource availability. This includes adequate and competitive funding to hire new staff to fill immediate gaps and retain current staff, ensuring continuity in providers (particularly peer support workers and clinicians) to facilitate trusting relationships; promoting equity in hiring and recruitment processes that values lived experience; and adequate training that equips workers with the skills and expertise to meet complex and diverse needs.

- **Long-term and sustainable investment are urgently needed:** Experts described a general lack of core, operational, and sustainable funding resulting in program insecurity and difficulties in longer-term program and organizational planning, diverting funds within organizations to keep critical programs operational, and challenges with hiring and staff retention. The COVID-19 pandemic galvanized policy attention at the federal, provincial, and municipal levels to confront Ontario's growing rate of PEH, and stimulated provincial investment for targeted initiatives. This policy attention should be leveraged for long-term, sustained investment in housing and primary and social care. Such investment should include adequate support for program operations/administration and staff.

- **Impact measurement:** Evaluation is critical to drive performance improvement, scale and spread effective initiatives, justify ongoing funding, and simulate returns on investment. Interventions cannot be fixed to funding as the realities of the communities being supported require that interventions be flexible, adapted, and iterated. Nimbleness is also an important principle in program evaluation. PEH clients are difficult to track outside the formal healthcare system, which has implications on evaluation. Quality improvement is driven by trial and error, and evaluation plans driven by logic models are informed by a strong understanding of what works and what does not. Metrics of measuring quality ought to reflect how a PEH flows through the ecosystem of support: one encounter with the program may represent several hours of work spread across multiple human resources; accordingly, metrics of evaluation will need to account for these complexities.

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Appendix A. Detailed Methodology

Literature review

We performed a targeted search of academic literature in three databases (PubMed, OVID(Medline), and ProQuest) using a combination of database-specific syntax and key words related to the population of interest (PEH), health and social care, programs/initiatives/interventions, and settings in Ontario (**Table A1**). All final electronic database searches were conducted and exported on August 8, 2023.

TABLE A1. Electronic database search strategy

MEDLINE	SYNTAX	RESULT
1	("homeless*" or "homeless persons" or "homeless youth" or "PEH" or "experiencing homelessness" or "under housed" or "no fixed address" or "vulnerably housed" or "unsheltered").mp. or (exp Homeless Youth/ or exp Ill-Housed Persons/ or Homeless Persons/)	18798
2	("care integration" or "health* services" or "social services" or "urgent care" or "primary care" or "self-referral" or "support*" or "equit*" or "access*").mp. or (exp Primary Health Care/ or exp Community Health Centers/ or Community Health Services/)	12309096
3	("intervention*" or "evaluation*" or "initiative*" or "program*").mp.	4177829
4	("Ontario" or "Toronto" or "Ottawa" or "London" or "Hamilton" or "Windsor" or "Sault Ste. Marie" or "Sudbury" or "Waterloo").mp. or exp Ontario/	135467
5	1 and 2 and 3 and 4	281
6	5 and 2016:2023.(sa_year).	156
7	limit 6 to (english language)	155
PUBMED	**SYNTAX**	**RESULT**
("homeless*"[All Fields] OR "homeless persons"[All Fields] OR "homeless youth"[All Fields] OR "PEH"[All Fields] OR "experiencing homelessness"[All Fields] OR "under housed"[All Fields] OR "lack of housing"[All Fields] OR "no fixed address"[All Fields] OR "vulnerably housed"[All Fields] OR "unsheltered"[All Fields] OR ("ill housed persons"[MeSH Terms] OR "homeless youth"[MeSH Terms])) **AND** ("care integration"[All Fields] OR "health services"[All Fields] OR "social services"[All Fields] OR "urgent care"[All Fields] OR "primary care"[All Fields] OR "self-referral"[All Fields] OR "support*"[All Fields] OR "equit*"[All Fields] OR "access*"[All Fields] OR ("primary health care"[MeSH Terms] OR "community health services"[MeSH Terms] OR "community health centers"[MeSH Terms])) **AND** ("Ontario"[All Fields] OR "Toronto"[All Fields] OR "Ottawa"[All Fields] OR "London"[All Fields] OR "Hamilton"[All Fields] OR "Windsor"[All Fields] OR "sault ste marie"[All Fields] OR "Sudbury"[All Fields] OR "Waterloo"[All Fields] OR "Ontario"[MeSH Terms]) **AND** ("intervention*"[All Fields] OR "evaluation*"[All Fields] OR "initiative*"[All Fields] OR "program*"[All Fields]) **Filters:** English, from 2016 - 2023		528
PROQUEST	**SYNTAX**	**RESULT**
ab("homeless*" OR "homeless persons" OR "homeless youth" OR "PEH" OR "experiencing homelessness" OR "under housed" OR "lack of housing" OR "unsheltered") **AND** ab("care integration" OR "health* services" OR "social services" OR "urgent care" OR "primary care" OR "self-referral" OR "support*" OR "equit*" OR "access*") **AND** ab("intervention*" OR "evaluation*" OR "initiative*" OR "program*") **AND** ab("Ontario" OR "Toronto" OR "Ottawa" OR "London" OR "Hamilton" OR "Windsor" OR "Sault Ste. Marie" OR "Sudbury" OR "Waterloo") **AND** la.exact("English") **NOT** stype.exact("Books" OR "Encyclopedias & Reference Works" OR "Newspapers" OR "Wire Feeds" OR "Blogs, Podcasts, & Websites") **AND** pd(2016-2023)		567

We used Covidence, a web-based management software, to remove duplicates and screen articles in two phases: 1) titles and abstracts, and 2) full-text articles. At the start of each phase, reviewers selected a random sample of five articles to screen and compare results to pilot the selection criteria. The titles and abstracts of citations whose eligibility was uncertain (rated "maybe") were directly included for full-text review; during full-text review, any uncertain articles were reviewed by the team. Articles were included if they met the criteria outlined in **Table A2**.

TABLE A2. Inclusion and exclusion criteria

Inclusion	Exclusion
- Academic and grey literature - Ontario - English language - Focus on connecting PEH with healthcare and social services - Can pertain to either youth or adults - 2016 and later - Article describes/evaluates/examines an intervention, strategy, or initiative to increase access to care	- Outside of Ontario - Before 2016 - Non-English - Commentaries - Focus is describing problems/barriers to care access without an explicit initiative to improve access to health/social services - Primary focus is on pandemic measures, infection control, or minimizing virus transmission

Key websites/organizations to search for grey literature

- Wellesley Institute
- Canadian Observatory on Homelessness (York University)
- Ontario Municipal Social Services Association (OMSSA)
- Health Quality Ontario
- Canadian Alliance to End Homelessness
- Salvation Army
- Homeless Hub
- Canadian Network for the Health and Housing of People Experiencing Homelessness
- Inner City Health Associates (Toronto)
- Ottawa Inner City Health (Ottawa)
- Canadian Mental Health Association
- Reach Niagara (Niagara)
- Shelter Health Network (Hamilton)

Expert Consultations

Invitations for expert review and consultation occurred between November 2023 – January 2024. Experts were identified from the literature, websites, and personal networks, and facilitated by members at the Ontario Ministry of Health. Consultations took place over Zoom and lasted between 30 minutes to one hour.

Appendix B. Summary of the Included Initiatives

Table B1. Entry Point 1 – Non-urgent/primary care health and social needs

Initiative Name / Sources	Location	Description	Date(s) Active	Impacts/Outcomes
Multi Agency Community Space (MACS) (ACCKWA, 2023)	Cambridge (Waterloo Region)	Collaborative drop-in hub for PEH. A full-time collaboration supporting homeless unsheltered individuals in Cambridge who are unable to access limited shelter space, by providing support for basic needs, mental health, the housing Prioritized Access to Housing Supports (PATHS) list for affordable and supportive housing, addictions treatment, primary healthcare, harm reduction, encampment outreach, overdose response, some nutrition support, and support for individuals with acquired traumatic brain injury. Partners include the AIDS Committee of Cambridge, Kitchener, Waterloo and Area (ACCKWA; lead), the Cambridge Food Bank, Langs CHC, Lutherwood Housing Services, Stonehenge Therapeutic Community, Canadian Mental Health Association, Sanguen Health Centre, and the Region of Waterloo.	May 2020 – Present	• **Service utilization**: In 2022/23, supported individuals through a total of 12,595 engagements; 5,020 harm reduction interactions, 1,032 healthcare interactions, and 402 housing inquiries; daily average 65 participants. • **Overdose prevention**: Naloxone distribution not published.
Hamilton's Social Medicine Response Team (HAMSMaRT) (*HAMSMaRT – The Hamilton Social Medicine Response Team*, n.d.; Nussey et al., 2023)	Hamilton	HAMSMaRT (incorporated as the HAMSMaRT Community Health Collective in June 2022) is a mobile outreach service of general internal medicine and infectious disease physicians, registered nurses, midwifery, and outreach workers whose goal is to provide medical care to individuals with barriers to accessing care in the traditional medical system. Mission to address the social determination of health through integrated community centred care, education, research, and community organizing.	Sep 2016 – present	• **Service utilization:** In 2018/19 had a patient base of 200 individuals, primarily those with who are homeless or unable to leave their home due to mobility difficulties. • **Client experiences:** qualitative study conducted in 2023. • Collects, analyzes and published data on the deaths of people deprived of housing in Hamilton (*Deaths in the Hamilton Homeless Population*, n.d.).

		Funding and/or partnership with: The Hamilton Community Foundation, The Karen and Peter Turkstra Family Foundation Fund, The McMaster Family Medicine Associates, James A., Burton & Family Foundation, the Ontario HIV Treatment Network, and Health Canada.		
Community and Service hub ("The Hub"), 602 Queens Ave. (Basa, 2023; London Cares, 2023b; Regional HIV/AIDS Connection, 2023)	London	The Community and Services Hub is a supportive environment based on the core values of dignity, hospitality, inclusion, community, social justice, persistence, and hope. Partners came together to develop the hub to co-create community and address housing and healthcare needs, and link to support and social services. The Hub is a joint partnership between London Cares Homeless Response Services, Regional HIV/AIDS Connection (RHAC), the Congregation of the Sisters of St. Joseph, and the Thames Valley FHT. Funding provided by the City of London, London Community Foundation, Ontario Trillium Foundation, the United Way Emergency Community Support Fund, and the Federal Government Enabling Accessibility Fund.	Jan 2023 – present	• **Service utilization** (Apr-Sep 2023): 469 new unique individuals supported; 11,521 visits were made by individuals seeking services, with a 31% service increase from Apr to Sep alone; 38,971 meals provided by St. Joe's Café; 1,131 times staff provided basic needs and system navigation at the door; 1,896 times individuals accessed a shower; and 919 loads of laundry done. • The team at 602 Queens Ave has also successfully helped secure housing for 13 individuals who regularly attend the Hub.
Health Outreach Mobile Engagement (H.O.M.E.) Program (Kovacs Group Inc., 2022; London Cares, 2023c)	London	The H.O.M.E. program is a collaborative initiative between 5 community partners. The mobile health clinic provides accessible, barrier-free, non-judgmental healthcare to individuals who are experiencing homelessness, are insecurely housed, or are rostered clients of the London InterCommunity Health Centre. Other services include: navigating the health and social service systems, harm reduction support, infectious disease testing, housing support, basic needs, and referrals to agencies and community service partners.	Jan 2021 – present	Winner of the 2021 Pillar Community Collaboration Award. Key findings from first year evaluation (Jan 2021 – 2022): • **Service utilization:**1,059 unique clients accessed medical and wraparound care services; 18 emergency medical interventions were given; 12 overdose responses were conducted.

		Financial sources: the Government of Canada's Substance Use and Addictions Program and Ontario Health West. Partners: 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.		• **ED diversion:** 1,175 non-essential emergency room visits were potentially prevented. • **Overdose prevention:** did not report on overdose outcome, only total # of overdose events. • **Client experiences:** 72% of clients reported improved well-being due to the program.
Regional Essential Access to Connected Healthcare (REACH) Niagara (REACH Niagara, 2022, 2023c)	Niagara	Aims to reduce barriers to healthcare for marginalized populations, specifically homeless people in Niagara. Provides non-judgmental and low-barrier healthcare services. They work with and operate primary care medical clinics that are staffed part-time by healthcare professionals, including doctors, foot-care providers, NPs, social workers, community outreach workers, and community partners. Services include ongoing primary care, select form assistance, connection to supports, counselling, harm reduction supplies, preventative care screening and referral. Funding sources: Health Canada, provincial government, Telus (mobile clinic), donations and local grants.	2018 – present	• **Service utilization:** As of Oct 2022, over 4,500 patient interactions with more than 750 clients since its launch. Between Oct 1-Dec 29, 2023, the Mobile Health Van served 913 unique individuals and provided 1,235 interventions (of which 457 were medical treatments).
Community Outreach Programs – Ottawa Inner City Health (OICH) (Campbell et al., 2020; Ottawa Inner City Health Inc., n.d.)	Ottawa	OICH offers a variety of outreach programs to further assist PEH with complex needs (e.g., diabetes). These outreach programs are offered in collaboration with several partners.	Unspecified – Present	• Support workers and their ability to often better build rapport with clients than traditional health care providers were the main reported benefit of the outreach programs (peer support, urban outreach diabetes collaboration, etc.).
Dymon Health Clinic (Ottawa Business Journal, 2023; Ottawa Inner City	Ottawa	Provides primary care and dental care to PEH, seven days a week – dental care is significant since it is not a service offered in most shelters/projects.	Jun 2019 – Present	• From 2018-2019: patient consults increased from 7,600 to 13,250, a staggering 74% increase.

Health Inc., n.d.; The Ottawa Mission, 2019, 2023)		Also offers women's care, a Hepatitis C community clinic, HIV care, infectious disease care, and foot care. The dental clinic is staffed by over 100 volunteer dentists, denturists and hygienists. The clinic has hosted specialty clinics by partners at the Ottawa Hospital, Bruyere Hospital, and more. The clinic is planning a dedicated space for an Ophthalmology Clinic to provide eye care for vulnerable people in the community. Funding: Dymon Group provided a gift of $300,000 in 2018 to The Ottawa Mission clinic support its expanded programming.		• In 2019: reported 579 dental related consults and treatments in the past year. • The Ottawa Mission's website reports 14,739 health clinic patient consults at the time of writing.
Enhanced Supportive Housing (Cornerstone, n.d.; Ottawa Inner City Health Inc., n.d.; Shepherds of Good Hope, n.d.-b)	Ottawa	In collaboration with community partners to offer six supportive housing environments aimed at helping various subpopulations of PEH—e.g., Booth House, the Oaks, Carruthers (Ottawa Inner City Health Inc., n.d.). • Booth House: at-home-aging program offered in partnership with Cornerstone Housing for Women to provide supportive housing and access to 24-hour health and social supports (Nurses, CCWs, medication management, meal programs, etc.) for 20 women aged 55 or older. • The Oaks: a collaboration with the Shepherds of Good Hope which specializes in providing addiction supports to members of the Indigenous community (40% of residents are either First Nations or Inuit). Centered around its Managed Alcohol Program (MAP), the Oaks organizes many activities and events to promote social connections and supports. • Carruthers: a 45-unit supported housing program offered by OICH in collaboration with the John Howard Society (JHS); includes Injectable Opiate Agonist Treatment (IOAT) program.	Unspecified	Carruthers: OICH's 2022–2023 annual report notes that Carruthers was successful helping many of its original residents migrate to other forms of treatment and to different environments where they can prioritize "volunteering, work and time spent with family and friends."

Managed Opioid Program (MOP), OICH (Campbell et al., 2020; Harris et al., 2021 Ottawa Inner City Health Inc., n.d.; Respect RX Pharmacy, n.d.)	Ottawa	Program offered by Ottawa Inner City Health (OICH), which pairs injectable hydromorphone treatment with assisted housing for individuals with severe opioid use disorder.	Aug 2017 – Present	After 1 year of implementation: • **Service utilization:** 96% were connected to behavioral health services. • **Substance use:** 45% stopped using non-prescribed opioids. • **Other:** 73% had reconnected with their estranged families and 31% started working.
Nurse-led HIV PrEP Program (PrEP-RN) (CATIE, 2022; Haines & O'Byrne, 2022)	Ottawa	A partnership between a safer opioid supply program and an HIV PrEP program, both of which were nurse-led. In this initiative, HIV PrEP was offered to individuals within the safer opioid supply program.	Dec 2020 – Jun 2021	• HIV PrEP was offered to 42 individuals within the safer opioid supply program, resulting in 55% (n = 23) participation in the program—appears to be a "highly effective way to expand access to HIV prevention among people who use drugs."
Targeted Engagement and Diversion (TED) Program, OICH (Ottawa Inner City Health Inc., n.d.; Zinn & Beaudoin, 2016)	Ottawa	The TED Program aims to provide accessible treatment and health care for PEH who have complex healthcare needs. Services are offered in a community setting rather than a hospital ED, to divert individuals from EDs while maintaining a high standard of care. Services include access to nurses and NPs, mental health and peer support, intensive case management, access to an internist, and a 24-hour medical monitoring service for those under the influence of drugs and/or alcohol to facilitate safe detoxification. This is offered by OICH in close collaboration with the Shepherd of GoodHope, embedded within the larger Temporary Enhanced Shelter Program (TESP)—an "integrated care system of medical and social work case management" (Zinn & Beaudoin, 2016)—that aims to provide low-barrier access to care and referrals to specialized	2013 – Present	• The latest annual report published by OICH (2022–2023) reports that the TED program accounted for 305 hospital diversions by emergency medical services from January–March 2023 (Ottawa Inner City Health, 2023). • In its earlier phases, a cost analysis from 2015 found that of 15,240 episodes of care (2013–2015), 1,852 were verified as being true ED diversions where care was provided in TED rather than in an ER; estimated a reduction of about $521,000 (Zinn & Beaudoin, 2016).

		supportive shelters or living environments, for individuals dealing with substance use issues (e.g., clients of TED), while also providing cost-savings for the healthcare system.		
Respect RX Pharmacy Pharmasave–Medical Supplies and Equipment Program (Campbell et al., 2020; Haines et al., 2022; Respect RX Pharmacy, n.d.)	Ottawa	An independent community pharmacy that serves inner-city populations—the sole dispenser of medications for residents staying in OICH sites. Also part of the initiative "Safer Supply Ottawa," a joint initiative of six organizations that provide comprehensive care and services to people who use drugs—*see Supervised Consumption Sites (SCS) below*.	Unclear – Present	• Reduced barriers for individuals who are in need of diabetic supplies (e.g., lancets, pen needles), by applying various subsidies and funding arrangements to cover their supplies and medications.
Special Care Units – Ottawa Inner City Health (OICH) (Campbell et al., 2020; Ottawa Inner City Health Inc., n.d.)	Ottawa	OICH has a variety of special care units within each of Ottawa's major downtown shelters, with beds reserved for individuals deemed to have complex health needs. Provide individuals experiencing homelessness with access to a variety of specialized in-shelter care (e.g., hospice care, palliative care, mental health and addiction care, and social supports to get and keep people housed) (Campbell et al., 2020). Detailed intake assessments are performed by trained registered nurses to closely monitor patients with a wide range of health conditions (e.g., one unit supplements health care with a co-located support worker who administers medications and monitors blood glucose levels, among other vital signs for PEH with diabetes [Campbell et al., 2020]).	Unspecified – Present	• A highlighted benefit reported by staff of the special care units was their tailored care that is best suited for individual needs—rather than a "one size fits all" diabetic regime. This feature was described as important due to clients often have chaotic or unpredictable living situations.
Supervised Consumption Sites (SCS) – Ottawa Inner City Health (OICH) (Haines et al., 2022, 2023; Kerman, Manoni-Millar, et al., 2020)	Ottawa	Provide a safe and hygienic space for people to use previously acquired drugs, access to sterile injection equipment, and medical supervision and intervention.	Unspecified	• Interviewed participants spoke about feeling a sense of community and acceptance, connection with peers and staff, trust and respect, and safety, among others. • Safe Supply appears to have some impact on housing status for

				participants; the number of participants in shelter decreased by eight in 2022, and three in 2023.
The Trailer (Ottawa Inner City Health, 2023; Ottawa Inner City Health Inc., n.d.; Shepherds of Good Hope, n.d.-a)	Ottawa	Supervised consumption and treatment service offered by OICH in collaboration with the Shepherds of Good Hope. Operates 14 booths, 24/7 and offers additional services, including primary care services, mental health care, and substance use treatment.	Nov 2017 – Present	2022/23: • **Service utilization**: Provides in average of 228 visits per day; excess of 7,000 visits per month; 39,091 referrals made to other services; 220 unique clients seen by case managers. • **Overdose prevention**: Reverses an average of 1.2 overdoses per day.
Inner City Access Program (ICAP) (Millward, 2018; Pauley et al., 2016)	Toronto	ICAP was established to meet the needs of marginally housed people with severe and persistent mental health and/or addiction issues. The goal of the program is to make access as low a barrier as possible for individuals. This service delivery employed by the Toronto Central Community Care Access Centre combines supportive housing services and health care for marginalized populations (e.g., PEH) using the shelter system. People can access the program by self-identifying and by referral. Integral to this approach is the co-location of an interdisciplinary primary care team.	Unclear	• **Service utilization:** 20 clients received service during a 15-month period before implementation. This increased to 147 clients during a 16-month period post-implementation • **Cost effectiveness:** average 60% reduction in cost per client.
Niiwin Wendaanimak Four Winds Wellness Program (Firestone et al., 2019; Parkdale Queen West Community Health Centre, 2023; Well Living House, Centre for Urban Health Solutions, St. Michael's Hospital, 2017)	Toronto	A Program launched by the Parkdale Queen West CHC (PQWCHC), under the guidance of the West End Aboriginal Advisory Council (WEAAC) that seeks to enhance health and community services for homeless and at-risk Indigenous populations. The program is focused on providing culturally specific Indigenous supports and access to healing ceremonies, health education, case management, access to primary care and harm reduction	Sep 2015 – Present	• A process evaluation was conducted in 2019. Qualitative analysis finding that "PQWCHC is meeting the needs of homeless and at-risk Indigenous populations in Toronto."

		supports, and social recreation activities to build social connections and support.		
Palliative Education and Care for the Homeless (PEACH) Program (Buchanan et al., 2023; Inner City Health Associates, 2023a; Parker, 2020; Robinson et al., 2023; Schneider & Dosani, 2021; The College of Family Physicians of Canada, 2023)	Toronto	PEACH is an interdisciplinary clinical outreach program that aims to meet the needs of homeless and vulnerably housed people with life-limiting illnesses. The program's focus lies with the pain, symptoms, and psychosocial goals related to end of life care for clients. PEACH operates a mobile unit to provide trauma-informed care in the community, on the streets, and in shelters. Clinical staff include palliative physicians, nurses, and social workers. PEACH accepts referrals from health care services, EDs, primary care, and hospitals. Since many community and social service providers do not have sufficient experience and skills to identify palliative care needs, the PEACH program made community educational supports a pillar of its model. Funding sources: Provincial health care funding (e.g., via the Ministry of Health and Long-term Care in Ontario) and through philanthropic funding.	Jul 2014 – Present	• **Service utilization**: The program has served over 1,000 people. An evaluation of the health navigator role logged 407 activities by the health navigator between Jun 2020 and Jul 2021, 207 of which were related to providing palliative care to PEH.
Partnership between the YWCA Elm Centre and Women's College Hospital (WCH) (Barker et al., 2022)	Toronto	An outpatient collaborative care initiative in which a psychiatrist was added to existing housing, community mental health, and primary care supports in a women-centered supportive housing complex.	May 2019 – Present	• Suggested that further work is warranted to evaluate whether collaborative care adaptations in supportive housing settings lead to improvements in tenant- and program-level outcomes.
StreetHealth (StreetHealth, 2023)	Toronto	StreetHealth is a non-profit, community-based organization working to improve the health and wellbeing of the homeless and under-housed population in Toronto. Services include drop-in primary care (via RNs and RPs), mental health, harm reduction, supplies and	1986 – present	• **Service utilization** (2022/23): 5,893 client contacts for primary care nursing, 6,554 for mental health, 1,810 overdose prevention site, 1,358 safer opioid supply, 6,243 harm reduction drop-in visits, and more.

		referrals, overdose prevention, and identification help (e.g., Ontario Health Card). Funding provided by: Health Canada, Ministry of Health, City of Toronto, fundraising and private donors (Toronto Overdose Prevention Society, private family foundations, churches and community groups, etc.).		• **Client satisfaction** (2022 client survey): 86% reported their health and wellbeing have improved from access to Street Health services.
West End Quality Improvement Collaboration (Callaghan et al., 2019; Filaber, 2021)	Toronto	A partnership of six CHCs established with the goal of increasing the efficiency and effectiveness of service delivery to serve the most marginalized populations, including PEH.	2015 – present	• Established common definitions of data elements, measures, and indicators an across the participating CHCs, to ensure comparability. • An analysis after the first year of the initiative found that cancer screening rates had improved among individuals in the marginalized populations being targeted by the initiative.
Windsor Essex Community Health Centre (WeCHC) on Wheels (Mobile Clinic) (Fraser, 2020; weCHC, 2022)	Windsor-Essex	A 38-foot-long bus equipped with two examination rooms, a registered nurse, and an NP, with the goal of bringing primary care to people having trouble accessing it. The objective of WeCHC on Wheels was to promote ED diversion by caring for patients without family physicians who would otherwise need to visit the ED for all their health needs.	Oct 2019 – 2022	*N/A - we could not find the results of any evaluations.*

TABLE B2. Entry Point 2 – Social Services

Initiative Name / Sources	Location	Description	Date(s) Active	Impacts/Outcomes and Financial Details (e.g., ROI)
Adolescent/young adult Connections to Community-driven, Early, Strengths-based and Stigma-free services (ACCESS) Open Minds (ACCESS Open Minds, 2021; Malla et al., 2019)	Chatham-Kent, ON (1 of 14 sites across country)	A pan-Canadian project using a model for transformation of services for youth with mental health and substance abuse problems that "aims to transform mental health services for young people aged 11 to 25 years and to evaluate the impact of this transformation on individual and systems outcomes." Focused on several youth populations, including homeless youth.	N/A	• Promotes engagement in community mapping of services followed by training, active stakeholder engagement, early case identification, providing rapid access to an assessment of the presenting problems, facilitating connection to appropriates service, and a structured evaluation to track outcomes over the period of the study. • An evaluation of ACCESS Open Minds was published in 2021. However, findings from each provincial/territorial site cannot be disaggregated.
The Vulnerable Persons Outreach Project (VPOP) (Martin et al., 2023; The Oshawa Express, 2018)	Durham Region	A mobile response team from Durham police department and other local partners aimed to support the needs of vulnerable individuals by identifying frequent police service users and individuals at risk of becoming involved with the law (e.g., PEH with mental health challenges), and proactively connecting with them before they experience a crisis situation.	Oct 2018 – Mar 2020	• **Service utilization** (first 18 months): the VPOP team completed 202 visits with 143 unique service users (19.6% being homeless at the time).
Kenora Makwa Patrol (CBC News, 2021; Kenora Chiefs Advisory Ogimaawabiitong, 2023; Punkari, 2023)	Kenora	The Kenora Makwa Patrol, which is administered by the Kenora Chiefs Advisory, provides a range of supports to people in need on a 24/7 basis, including handing out meals and water, connecting and transporting people to additional services, and supporting emergency response by police and ambulance services. Supports provided from organizations in Kenora, such as the city council, Kenora District Services	2020 – present	• **Service utilization:** In the last year, completed 3,744 wellness checks, 9,731 area checks, provided 7,490 safe rides, and handed out 22,952 items of food and 10,560 drinks and 1,162 blankets and items of clothing. • **Diversion**: the street group has "helped take pressure off police and ambulance services in the city, because people are able to call the

		Board, the OPP and Treaty Three Police Service, and the general public.		Makwa team for support or crisis intervention."
Street Outreach, London Cares (London Cares, 2023d)	London	London Cares has two street outreach teams that operate 24/7 to engage individuals experiencing homelessness, building trust to connect people to services and housing. Their teams work with all acuity levels, with a specialization in supporting those with a high acuity, and we work with all individuals, couples, youth, and people of all genders, including many from the LGBTQ2+ community. They also help individuals get ready for housing (e.g., complete documentation) so they can be placed on London's Coordinated Access Priority List for Housing. Works closely with police and emergency services, emergency shelters, the Coordinated Access team, the City of London Housing Stability Services team, and other agencies in the Homeless prevention system.	2012 – Present	In the last year: • **Service utilization:** 426 unique individuals engaged and 6,719 campsite + outreach engagements; 3,641 referrals to services and 2,713 system navigation supports; responded to 84 instances of overdose. • **Diversion:** 63 individuals diverted from hospital and 44 individuals diverted from EMS. • **Harm reduction:** distributed 2,080 naloxone kits. • **Overdose prevention:** Did not report on overdose outcome, only total number of overdose events responded to.
Gambling Addiction Program (GAP) (Matheson et al., 2022)	Toronto	A program to reduce gambling harms among clients experiencing poverty, homelessness and multimorbidity, offered by a shelter service agency—Good Shepherd Ministries (GSM). GSM was awarded $759,00 in 2016 from the Local Poverty Reduction Fund to evaluate the impact of the program (Ontario, 2017).	Apr 2017 – Present	• GAP supported participants in the process of recovery, enhancing their understanding and control of their gambling selves, behaviours, and harms. GAP stands as an effective, comprehensive approach to care and a model to emulate within other shelter service agencies.
Housing Outreach Program Collaboration (HOP-C) & HOP-C-North (HOP-C Working Group, 2020; Kidd et al., 2019;	Toronto; Thunder Bay	HOP-C is an example of a critical time intervention that is comprised of transitional outreach-based case management, group and individual mental health interventions, and peer support to facilitate the transition out of homelessness for youth, with a focus on preventing the reoccurrence of homelessness.	2015 – Unclear	• **HOP-C (Toronto):** This tertiary prevention approach holds promise as a complex intervention that can help address the complex needs of these young people transitioning out of homelessness.

Lund et al., 2022; Toombs et al., 2021)		The program includes a multicomponent and collaborative design with strong levels of community engagement to appropriately adapt the program's design to client needs. In Toronto, transitional case management is provided by LOFT and Covenant House Toronto; peer support and engagement by SKETCH; and mental health and wellness support by CAMH. HOP-C was awarded $978,900 in 2016 from the Local Poverty Reduction Fund to test proof-of-concept in Thunder Bay (HOP-C-North) with Indigenous youth, and for a trial in Toronto to determine effectiveness (Ontario, 2017).		• **HOP-C-North:** Participants reported improvements in a number of outcomes, including increased educational enrollment, attainment of employment, reduced hospitalizations, and increased engagement in clinical mental health services.
Peer Education and Connection Through Empowerment (PEACE) (Covenant House Toronto, 2021; Kahan et al., 2018, 2020)	Toronto	A peer-supported and trauma-informed group intervention of approximately three months duration, aimed to support and empower young (ages 16–24) female-identified survivors of gender-based violence experiencing homelessness. A 2021 report notes that the project "intends to be scaled up in the new phase by expanding work with all genders and prioritizing working with LGBTQ2S young people and Black young people by developing additional partnerships with organizations who specialize in supporting these groups of young people." Partners: Centre for Addiction and Mental Health (CAMH) for research. Funding was provided by the Public health Agency of Canada (October 2015 – September 2020).	2017 – 2022	• **Client satisfaction and quality of life**: Qualitative results showing that interventions were seen as acceptable to both service users and organizational stakeholders. The overall quality of life score increased significantly over 12 months among participants, and the experience of victimization decreased significantly over 12 months among participants, compared to baseline.
Reintegration Centre (McLuhan et al., 2023)	Toronto	A re-entry service hub for men released from custody (histories marked by homelessness, addiction, violence, trauma, discrimination, etc.,	Unclear	• Mixed-methods process evaluation of 209 clients (Sept 2017–Dec 2018) found that the peer-led service hub model enhanced the service

		and staffed by peer support workers with lived experience with criminal justice involvement. The centre was established by the John Howard Society of Toronto near the Toronto South Detention Centre. Services include immediate supports, including access to clothing, food, transportation, and harm reduction resources (e.g., Naloxone kits), and longer-term access to additional supports at the John Howard Society to support transition back into society.		encounter experience and efficiently and effectively addressed re-entry needs through the provision of basic supports and individualized service referrals.
The Supporting Transitions and Recovery (STAR) Learning Centre (Durbin et al., 2021; Khan et al., 2020)	Toronto	Supports individuals transitioning out of homelessness by offering classes and workshops taught by peers with lived experience of housing instability and mental health challenges, as well as social and health service professionals; operating the centre as a hub-and-spoke model. Classes focus on life skills related to transitioning from homelessness to housing and other topics. The STAR Learning Centre Team includes peer support specialists, team leader, administrative assistant, psychiatrists, clinical leader manager, research coordinator, and a Community Advisory Committee.	Apr 2014 – Present	• Quantitative assessment suggests program is effective for improving empowerment and mastery outcome domains at 12-months. Participants described the classes environment as welcoming and respectful with low barrier seamless access facilitating their engagement and participation. • The involvement of peers as role models and the self-directed, strengths, and sills-based curriculum were instrumental in activating the process of recovery through education.
YMCA Sprott House (Abramovich & Kimura, 2019, 2021; CMHC-SCHL, 2020; Miller, n.d.; YMCA Greater Toronto, n.d.)	Toronto	A 1-year transitional housing program designed specifically to meet the needs of LGBTQ2S youth. Consists of 25 individual units with their own washrooms, two shared kitchens, two shared lounges and two staff offices. Youth are supported by a team of case managers and youth workers who provide direct support, make referrals, run programming, and manage potential crises. Partnerships exist with other agencies, including community medical health centres, violence against women programs, programs for	Feb 2016 – Present	• **Client experiences:** Youth participants were generally grateful to be the first group to live in the program, yet some wished that it had been more developed during their stay. Youth noted that many changes occurred as program administrators tried to figure out what worked and what did not; for this reason, the evaluation captured many of the program's growing pains. Youths' perception of safety in daily life

		Indigenous youth, an organization that provides a mental health outreach worker onsite weekly, and two substance use support programs. Practical supports provided at Sprott House include case management, social, recreational, and arts-based programming, life skills development, group and community processes, advocacy and informed referrals, and support related to substance use and sexual health, mental and physical health, and employment and financial literacy.		increased throughout their time at YMCA Sprott House (78% at intake vs 100% at exit). After 1 year, unemployment rate decreased from 85% to 69% , and school enrolment increased from 39% to 56%. • Overall, the study reveled that the program has positively impacted youths' mental health, sense of safety and transition to adulthood. • Plans to initiate a longitudinal mixed methods evaluation that will assess how the program affects outcomes for youth over time across numerous indicators, including mental health and well-being.
John Howard Society (JHS) – Rita Thompson Building (Din et al., 2018)	Ottawa	Has a primary focus on supportive housing for men who experienced long term homelessness. Case workers from JHS are available on-site 24/7, and also offers on-site medical services provided by Ottawa Inner City Health (OICH). The objective is to reduce tenant involvement in the criminal justice system and hospital through diversion.	2015 – Present	• JHS administers a survey annually that tracks tenant goals, including employment and increase in finances. However, staff point out that for many of their tenants, the seemingly simple or small changes are hugely impactful and transformative. Many of the outcomes are noticed by program staff but not necessarily captured in formal measurements.
Mobile Outreach Support Team (MOST) (Campbell, 2019; CBC News, 2019; Janzer, 2019; *Mobile Outreach and Support Team (MOST): Windsor, ON*, 2019)	Windsor-Essex	A fully accessible van with a team of specialists (a social worker, an outreach worker, and a personal support worker) to provide mental health supports to homeless persons in the downtown region of Windsor. The objectives are to provide basic needs by distributing essential goods; provide immediate mental health supports; and establish connections to additional services.	2019 – present	• **Service utilization:** 1,716 visitors between Jan. 31 and July 31, 2019 (~75% men). Nearly 25% of the MOST van visitors sought out mental health and addiction services, and 13% sought out medical care; MOST has given supplies during 94% of visits and provided motivational counselling during 26%.

		The project is a joint venture between Hotel-Dieu Grace Healthcare, CMHA-WECB, Family Services Windsor Essex and Assisted Living Southwestern Ontario (ALSO). The program launched in 2019 as a pilot where the van was active for six months and undergo evaluation for two months thereafter. A project charter, program logic model and evaluation plan were established.		• **ED Diversion:** Intention to measure "reduced crisis events/ED visits" and other long-term outcomes in initial logic model; however, could not locate a more recent logic model with these measures or outcomes reported.
Bridges to Housing (B2H) (Lamanna et al., 2020; Reid et al., 2021)	Toronto	Offers immediate access to housing of participant's choice via rent supplements, in conjunction with coordinated health, housing and social support services from the health, social services, and Intellectual and Developmental Disabilities (IDD) sectors. Funding support provided by Developmental Services Housing Task Force of the Ministry of Community and Social Services and the City of Toronto (City of Toronto, 2016).	Unclear	• 12 months post-enrolment, 24/26 (92%) of participants were successfully housed and reported increased QOL scores and decreased perceived unmet service needs. Individual-, intervention- and system-level characteristics facilitated housing stability in this population. • As of 2021: 28 of 29 clients in or discharged from the program remain successfully housed.
Big Island Model (BIM) (Marshall et al., 2022)	Prince Edward County	A model of permanent supportive housing (PSH) designed to address rural homelessness.	Unclear	• Compared with participants in other studies, mental well-being was reported to be higher and drug use was significantly lower than a low-moderate range. Community integration scores revealed significantly lower physical integration and significantly higher psychological integration than individuals who had transitioned to housing in another study.
Mino Kaanjigoowin (MK) program at Na-Me-	Toronto	Program at Na-Me-Res (Native Men's Residence) that supports Indigenous men who are experiencing homelessness or are precariously housed and who have complex health and social needs. The MK program aims to assist members with locating and securing	2008 – Present	A mixed-methods process evaluation was conducted in 2017–18 by the Well Living House in partnership with Na-Me-Res. Results indicate that:

Res (Native Men's Residence)[4] (Firestone, Syrette, et al., 2021; Well Living House, 2019)		appropriate, stable housing and to provide culturally safe case management, nursing, and psychiatric care. The MK program follows a Housing First Model: in order to maintain housing, MK members sign a "Good Neighbour" agreement and have bi-weekly check-ins with case managers, and case managers develop relationships with landlords. People come to the MK program through the Na-Me-Res shelter or related programs, or are identified by Na-Me-Res outreach workers. The MK team consists of case managers, traditional Elders and teachers, a nurse, and a psychiatrist who is on site at Na-Me-Res. Funders of Na-Me-Res include government agencies (Aboriginal Labour Force Development Circle, Canada Mortgage Housing Corportation-Urban Native Housing, City of Toronto, Heritage Canada, Miziwe Biik Aboriginal Employment and Training, Province of Ontario, and United Way of greater Toronto); several foundations and corporations, and donors (Na-Me-Res, n.d.).		• the MK program provides a unique healing model that is grounded in trust, honour, and respect; • strengths include a harm reduction framework, meeting basic needs, and person-centered care; and • the program could be enhanced through increased human resource capacity and improved infrastructure.
Cambridge STEP Home Collaborative (Din et al., 2018)	Waterloo	A pilot program designed to connect chronically homeless individuals with community landlords in Waterloo Region. This program uses a three-phase approach to transition homeless individuals into housing. Subsequently supports tenants to maintain their housing following a five-stage work plan to recover from homelessness, including supports to enhance self-care, mental health,	Unclear – ended	• Service utilization: Exceeded their initial goal of housing 50 participants within a 2-year project, for a total of 62 individuals housed. • Client outcomes: 11 of the 62 people retuned to homelessness, but 8 were re-housed through the program. Thus, the program successfully housed and

[4] Na-Me-Res is a registered charity that started in 1985. Na-Me-Res operates various other housing supports and projects, including affordable housing units throughout Toronto, as well as Indigenous-specific street outreach. More information about Na-Me-Res can be found on their website: https://www.nameres.org/

		addictions, legal issues, money management, transitional planning, and more. The target population included anyone from the PATHS (Priority Access to Housing Services) list, a by-name list of PEH in Waterloo Region. This program was initiated following the Region of Waterloo's 2007 *All Roads Lead to Home* homeless and housing stability strategy. Four organizations: Lutherwood (lead), Argus Residence for Youth People, Cambridge Self Help Foodbank, and Cambridge Shelter Corporation were funded by the Region of Waterloo via federal and provincial funding.		supported 59 individuals into housing within the community. • Challenges with the collaboration were noted, such as inconsistencies with human resource matters.
Other Housing First[5] (Cherner et al., 2017; Din et al., 2018; Forchuk et al., 2022; Kerman, Aubry, et al., 2020; Kerman et al., 2018; Kumar et al., 2017; Latimer et al., 2020; Mejia-Lancheros et al., 2020, 2021; Nelson et al., 2017; O'Campo et al., 2016; Peng et al., 2020)	Various locations	Several (15+) articles describe various Housing First-related programs. Some examples include: • Housing First program in Ottawa for adults with problematic substance use (Cherner et al., 2017). • Housing intervention for veterans experiencing homelessness using a Housing First approach in four Canadian cities (Forchuk et al., 2020). • Housing First with assertive community treatment in five Canadian cities (Latimer et al., 2020). • Systematic review of permanent supportive housing with Housing First for homeless persons with a disability (Peng et al., 2020).	N/A	These studies explored outcomes of Housing First programs, including service use, hospital use, incarceration, changes in mental health, cost effectiveness, quality of life, community integration, and more. Also explored were successes and challenges for integrating Housing First within existing service systems, as well as sustainability.

[5] We identified several articles describing various initiatives/programs following the Housing First approach to improving access to health and social services for PEH. Given the large volume of articles, and that these programs are already well-studied, we do not describe all of these programs in detail.

TABLE B3. Entry Point 3 – Urgent self-referral

Initiative Name / Sources	Location	Description	Date(s) Active	Impacts/Outcomes
Highly Supportive Housing (LHSC, 2023; London Cares, 2023a)	London	In partnership with the London Health Sciences Centre, London Cares operates 25 supportive housing units, using existing fully furnished apartments to provide individuals with comprehensive 24/7 health and social supports. London Cares has been working with LHSC to determine a cohort of individuals with complex needs to divert them from inpatient stays or ED visits. This joint project is under the umbrella of the *Health & Homeless Whole of Community System Response* in London. This initiative is also supported by Home and Community Care Support Services, London InterCommunity Health Centre, H.O.M.E. program collaborators, the Sisters of St. Joseph (ensures residents receive at least one hot meal per day), and Voyago Health (provides complimentary transportation services to the building once residents are ready to move in).	Oct 2023 – Present	N/A – Evaluations are underway and findings have not yet been published.
CATCH (Inner City Health Associates, 2023b, 2023b; Lamanna et al., 2018; Reid, Brown, et al., 2022; Reid et al., 2021; Reid, Mason, et al., 2022; Stergiopoulos et al., 2017, 2018)	Toronto	A referral-based program in Toronto that assists PEH discharged from hospitals who are not connected to services (with or without mental health or addiction problems) immediately access health resources in their community. The aim is to reduce preventable hospital visits and improve and coordinate access to care for homeless populations who visit the EDs and inpatient units of hospitals.	2010 – Present	• **Service utilization:** As of 2016, 1,678 referrals had been made in the first five years, and approximately 1,300 clients had been connected to a CATCH-affiliated family physician. • **ED diversion:** An evaluation of an earlier version of CATCH demonstrated a 14% reduction in ED visits but did not find a significant difference in health outcomes.

Navigator Programme (Liu et al., 2022; MAP Centre for UrbanHealth Solutions, 2023)	Toronto	A time intervention case management program that was developed to help homeless patients with their post-discharge needs and to link them with community-based health and social services. The ultimate goal is to help homeless patients who are discharged from the hospital overcome systemic barriers and discontinuities in care that often result in poor health and high acute care utilization. The program is embedded in the hospital care team at St. Michael's Hospital, has staff with homelessness-specific expertise, and includes a flex-fund to meet immediate patients needs (e.g., transportation to/from appointments, items to improve hospital comfort and lower changes of early self discharge, and health-related costs while income supports are established. This program features Homeless Outreach Counsellors (HOCs), whose roles are to create strong linkages between community service and patients through regular contact, supporting patients following their post-discharge care plans, and helping patients meet health and social related priorities. One or more trained HOCs each carry a caseload of 15-20 patients at any given time, and follow patients for approximately 90 days following their hospital discharge.	2021-Present	An RCT protocol to assess the effectiveness of the Navigator Programme in improving posthospital outcomes among adults experiencing homelessness (n=640 adults) began in 2021. The RCT protocol was published in 2021, outlining recruitment and data collection methods, data linkage, outcomes, analysis, and stakeholder involvement. To our knowledge at the time of writing this report, the findings of the RCT have not yet been published.
UHN Social Medicine Housing Initiative (Parkdale Housing & Health) (City of Toronto, 2023; Khandor et al., 2011)	Toronto	The first initiative in Canada to provide permanent supportive housing for 51 UHN patients who are marginalized and high utilizers of acute care services. UHN's Social Medicine Program will provide comprehensive primary care onsite and address underlying social determinants of health through various social care interventions. A framework for the program has been established through a Memorandum of Understanding between the City of Toronto, United Way, and UHN.	2024 – present	N/A – Evaluations will be conducted once the program becomes operational.

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