# Health Outreach Mobile Engagement


**A response to the converging public health crises: opioid poisoning and overdose, COVID-19, and housing precarity**

## THE ISSUES

With federal funding in early 2020, the Health Centre was set to scale up and formalize into a mature safer opioid supply program. However, in March, the emergence of the COVID-19 pandemic derailed many health and social services, and the Health Centre's plans for program scale up.

The issues facing our clients became three-fold: opioid poisoning and overdose, COVID-19, and housing precarity. Connections with clients became hampered by the pandemic and the Health Centre's new screening protocols. The Health Centre responded to the converging public health crises through outreach and engagement with the Health Outreach Mobile Engagement (HOME) program.

## THE SOS PROGRAM

The Safer Opioid Supply (SOS) program has been designed to provide comprehensive healthcare and wrap-around services to support people who use drugs. Physicians prescribe pharmaceutical opioids to clients to replace the toxic supply they rely on. This model creates stability for clients as they start on a path to greater health and wellness.

The program focuses on a client-centered and team-based care model within our Health Centre. In addition, a peer advisory committee and peer mentorship are key elements of this program's success.

## THE HOME PROGRAM

To re-connect with clients and ensure delivery of comprehensive care, the Health Outreach Mobile Engagement program was developed to take the SOS program to the clients, where they are at: in COVID-19 hotels, in shelters, in encampments, in their housing, and in other community settings.

## GUIDING PRINCIPLES

- People who use drugs are experts
- Participant-led and participant-centered care delivery
- Harm reduction
- Low-barrier care
- Non-punitive approach

## TARGET POPULATION

The HOME program is intended to reach highly vulnerable community members who face barriers to accessing traditional models of healthcare and social services. The target population includes those who are homeless, insecurely housed, or under-housed.

London InterCommunity Health Centre

## SERVICES PROVIDED

- Triage and assessment
- Basic medical care - wound care, treatment for infections, access to medications, safer opioid supply, testing (HIV and Hep C), blood draws and urine screens
- Harm Reduction equipment, supplies, and information
- Healthcare and social services system navigation
- Housing support
- Case management
- Crisis intervention and support
- Advocacy
- Provision of basic needs
- Peer support

## TEAM COMPOSITION

Services will be delivered by two groups of three to five team members, including two primary care providers and one to three other team members (outreach workers, system navigator, and social worker/mental health worker).

## INDICATORS OF SUCCESS

- Decreased use of street drugs
- Decreased money spent on street drugs
- Increase access to primary care
- Decreased anxiety and an increased sense of control
- Improved health status
- Decreased withdrawal symptoms
- Decreased overdose rates

## COMMUNITY PARTNERS

This program is proud to be working in collaboration with so many great partners including Regional HIV/AIDS Connection, Unity Project, Atlosha Family Healing Services, My Sisters' Place, Men's Mission, and Salvation Army Centre of Hope.

Every One Matters.