January 2022 *Janet Bickerton R.N., B.N., M.Ed*

Ally Center Outreach Street Health Pilot
Final Report
Oct 1 2020 – Sept 30 2021

This is the final report for the Ally Center Outreach Street Health (OSH) demonstration pilot.
The purpose of the outreach street health pilot was:

- To develop an effective model of outreach street health care.
- To provide barrier free primary care to vulnerable populations "where they are".
- To engage stakeholders to build and strengthen relationships to ensure vulnerable populations in the CBRM continue to have improved access to primary care and other health and social services.

This final report will highlight activities, insight/s and developments from the pilot with extra emphasis on the 4th quarter. The growth of the OSH service in this last quarter of the pilot is very much cumulative; with each initiative and service building on what we have learned from the previous quarter. This in itself is one of the key assets of OSH – flexibility, this along with openness and the willingness to learn from the population we serve. Not the organization, the funders nor the street health nurse have been tied to street health needing to be "rolled out" in a certain way and this has been a strength in the development of street health. We did however have clear objectives and we charted a course based on our needs assessment research along with the guidance of our experienced partners at Mobile Outreach Street Health (MOSH) in the HRM. This one year demonstration pilot has been about getting on the street and making street health real, effective, and aimed at truly helping those most vulnerable.

With Gratitude:
The Ally Center and the OSH Advisory Committee extend sincere gratitude to the Harm Reduction Implementation Team (HRIT) and Public Health for providing funds for the one year CBRM Outreach Street Health pilot. It was a chance encounter that gave us the opportunity to share with HRIT our enduring efforts to enlist support to implement street health, and that chance encounter resulted in the HRIT responding with the funds to implement a one year pilot. We also extend our thanks to the HRIT for assisting us with human resource expertise, specifically, Dorian Watts, who helped with the development of a logic model and evaluation plan. As well, we would be remiss not to mention our cherished memories of our dear friend and colleague, Dr. Margaret Dechman, as we write and share this final report.

Introduction:
Included in this final report is a financial report for the pilot period and to follow will be an evaluation report conducted and prepared by external evaluators. The external evaluation report will speak to the impact of street health taken directly from interviews held with OSH clients, and from community and government agencies and health partners. As in the other quarterly reports, this final report will be organized according to the domains of work that were identified in our proposal and evaluation plan. Those domains are: build and strengthen relationships; provide primary care and facilitate access to services; planning, development, &

sustainability, and advisory committee work. Some of the significant challenges we encountered will be shared as well as our efforts and hopes for outreach street health sustainability and growth.

It is truly amazing what 12 months of funding and support can result in and we are pleased to share the story of the "one nurse" street health model. Over the course of the one year pilot, trust has been built and services have been modified to meet people "where they are". We are overjoyed with the growth and impact of street health services over the duration of the year. Some key components of the pilot that have contributed to the success of street health are important to highlight:

- Having the "right" street health nurse with the experience, connections and passion for the work.
- Imbedding the street nurse in community within the Ally Center working closely with the Ally Health Clinic team.
- Having the support and partnership of a multitude of community based agencies.
- The Ally Center's Mobile Supportive Spaces Van. The Federal Reaching Home program via our local Reaching Home advisory board provided funding to support the purchase and ongoing operations of the van. This van and the peer helpers who staff the van have been critical to our ability to be "mobile" and provide street health throughout the CBRM.
- The willingness of those who are most vulnerable and street involved to trust and use the street health services that were offered.

With the HRIT funds *($98,760.00),* our street health nurse, Sharon MacKenzie RN, provided street outreach primary care 4 days per week while the Ally Center health services coordinator, Janet Bickerton RN, focused one day per week on the developmental aspects of the pilot. As well, with additional funds and in kind contributions from the Ally Center and the Reaching Home program, we were able to fund administrative support, consultant fees for the MOSH program, travel, rent, and harm reduction equipment, etc. Important to note is the in-kind contribution from the Cape Breton Community Housing Association (CBCHA) who partnered with the Ally Center to provide a .5 housing support position to work with street health.

COVID 19

I assume there are no reports submitted during the last two years that don't include some discussion of COVID 19 and its impact on the delivery of health services. COVID has been a focus over the course of the street health pilot as our concern for the risk and health of the street population has heightened. Early on, it was a serious challenge for Ally and other community organizations in the CBRM to get any COVID response for our most vulnerable despite continued offers of assistance to organize a coordinated effort. The Ally Center did ultimately play a key role in bringing community and health agencies together to advocate for actions aimed at protecting our street involved and homeless population. We sought funding for and opened a comfort site and had portable washroom/ toilets placed throughout the CBRM, and we initiated a COVID working group that continues to meet. After much advocacy, toward the end of April, street health became a key partner in COVID 19 testing and tracking, and facilitating access to vaccination. Below are some highlights re the street health role in the COVID response:

- The need for COVID rapid testing provided access to the population and seems to have accelerated and enhanced relationships with both individuals and with community partners. The OSH nurse performed 955 rapid tests from May to the end of September (end of the pilot period). The OSH nurse offered testing at the Ally Center itself and provided testing at community sites where people were most at risk such as homeless shelters, soup kitchen, food banks, corrections half way house, etc. Using the Mobile supportive spaces van, the OSH nurse and mobile peer helpers offered repeat pop up clinics in the surrounding communities to encourage and provide COVID testing (New Waterford, Glace Bay, Whitney Pier, Sydney Mines, North Sydney, and Louisbourg).
- Community partner agencies tell us that having the OSH nurse available throughout the COVID pandemic has been extremely helpful. The street nurse's response has been fast, easy, and her approach works for their population. They have called upon the OSH nurse for advice and information. She has gone directly to their sites to offer testing and education and has helped them navigate the "mini crises" that occur when someone is found to have had a positive test. In such circumstances she has gone to the community sites to do repeat testing and follow up, and to liaise with public health on behalf of these agencies.
- It is no surprise there have been significant challenges with many in our population who are uninformed or who are afraid to be tested and vaccinated. With some education and encouragement and because of the trust they have in the Ally Center and the OSH nurse, people have agreed to be tested, repeat tested, and vaccinated.
- When vaccine became available the OSH nurse and peer helpers who staff the mobile, would book people for their vaccine appointments, and arrange transportation when necessary.
- Most recently the local public health team has reached out to street health for assistance in developing strategies to vaccinate the local street involved and high risk populations. The local public health staff, who are well aware of the Ally and our connection to community, has enlisted street health to work with them to plan and implement vaccination clinics that are now being held inside the Ally Health Clinic and to organize clinics in other communities via our street health contacts (i.e. Glace Bay Food Bank).

Build and strengthen relationships

Relationships with service users/ clients:

- Help seeking behavior continues to increase as people from the target population within Sydney and in outlying communities seek out the services of the OSH nurse. People come to the Ally Center looking for the nurse, mobile peer helpers are responding to requests and are facilitating an increasing number of visits with the OSH Nurse, and community agencies are linking their clients with the street health nurse. The street health nurse need simply step out onto the street and she is approached with questions, concerns, and health problems that require attention. The Director of the Homeless shelter has indicated that street health has become an integral part of the services they provide to those experiencing homelessness.

- The Ally Center staff and Health Clinic team benefit from OSH involvement in many of their client encounters. The needle exchange workers frequently reach out to the OSH nurse regarding clients of concern and the Ally health clinic team have stressed that outreach street health has become a critical function of clinic services. The Ally physicians and the NP often involve the OSH nurse both proactively and for client follow up. Conversely, the OSH nurse frequently triages and facilitates access to the Ally clinic for those who are not connected and need to be assessed and treated by a physician or NP.

Relationships with Community partners:

- Key community based agencies in the Sydney area that have worked most closely with OSH are the Community Housing Homeless Shelter, Loaves and Fishes (the soup kitchen) and the Ally Center including the Sharp Advice Needle Exchange. There are over200 individuals daily who use these 3 service agencies alone, which are all located within blocks of each other. Many of the people these agencies serve live or are sheltered within walking distance and the streets are their home. This population is extremely high risk with most using substances dangerously, and living with untreated or unmanaged mental illness. Although the Ally Center has had positive relationships with these key organizations over the past 30 years, street health has resulted in them having daily interactions, working together to problem solve, and connecting to locate and help individuals in need. Having the street health service accessible to these organizations has totally changed the dynamic and there is now an obvious team approach resulting in more concrete and coordinated action to help our most vulnerable.
- There are other agencies located in close proximity to the Ally Center such as the John Howard Society, E.Fry Society, Transition House for Women, Cardiel Place (day program for those living with mental illness in community), and the Jane Paul Center for Indigenous Women. Although there is less frequent contact with these organizations, the OSH nurse regularly checks in with these agencies and responds when called upon.
- The Ally Mobile Supportive Spaces Van has helped to create a consistent presence in outlying communities. The Mobile travels a weekly route and parks in consistent, safe, frequented locations in these communities. The OSH nurse and the peer helpers who staff the mobile work closely with organizations like the Glace Bay Food Bank, the North Sydney Food Bank, and Community Cares in Sydney Mines to connect with those likely to need street health services. Relationships with these community organizations have most definitely been strengthened, and clients are often referred to the mobile and to the OSH nurse through these organizations. In a community like New Waterford where there is no food bank or street front agency to partner with, the mobile has consistently parked on the main street of the town for the past 2 years.
- Many people know “why” the van is there but interestingly during the past several months, more citizens have approached the van and have had discussions with the street health nurse questioning what the services are and for whom. This often leads to discussions around harm reduction, etc. The mobile is having more visitors because of the presence of the street health nurse where now additional services such as blood work for STBBI, flu shots, COVID testing, wound care, and referrals, are all happening via the mobile unit.

Cape Breton Community Housing Association: The Cape Breton Community Housing Association created a half time position for a housing support worker to be part of the OSH team. From Dec 2020 to the end of the pilot period, there have been a total of 40 referrals that have come to the housing support worker through the Ally Center. Currently there are 12 people on the supportive housing worker's caseload and 13 others have been housed. Words from the housing support worker:

> *Being on the mobile bus has been a great way to get out in the community and reach out to those in need. A lot of our clients don't have phones or ways of reaching us, so being out in the community allows them to get access to services on more of a walk in basis which helps them tremendously. I'm able to speak to them one on one and offer services or referrals to resources within the community that they may need help with.*

Cape Breton Correctional Facility: Another population the Ally works with frequently are those released from the local correctional facility. This population is frequently released, with minimal discharge planning, to the street. Many find themselves seeking help from the Ally and the nearby community based agencies. This is a unique population facing the significant challenge of re-integrating into society. They often find themselves homeless with complex health issues that require medical care and without a physician or health provider. As well, for those with substance use disorder, their risk for overdose has increased due to reduced drug tolerance while incarcerated. Many hours are spent by Ally Staff, the Ally Health Clinic and the OSH nurse to follow up and provide health care and link this population with needed services. A good working relationship with the social worker at the correctional facility has made a positive difference but communication between the health services team at Corrections and the Ally Health clinic have never been formally established. Street health has helped to identify the challenges and concerns with this population and we have reached out to begin a dialogue between the Corrections health team and the Ally Health staff. A meeting is planned for January of 2022.

The Cape Breton Regional Police service is an organization that the Ally Center has had a relationship with dating back to the opening of the needle exchange program 27 years ago. With the inception of street health this relationship has changed and improved significantly both at the systems level and street level. The input provided by street health has changed the conversation with police and both officers and street health see the benefit of continuing to work together. The police are tasked to respond to street situations and they must also respond to complaints from the business community and citizens. For the most part it seems local police attempt to use an educational approach when responding to complaints and they are generally supportive of harm reduction efforts, similar to other policing agencies across Canada. Working with street health has no doubt enhanced their understanding and their capacity to use harm reduction approaches to their policing work.

- The OSH nurse has reached out to police and worked alongside street officers to do wellness checks and to diffuse tense situations on the street.
- The current chief of police has been publicly supportive of both the Ally Center and specifically has appreciated Street Health, noting the important role it plays in creating a healthier community.
- Through the help of the police chief, a long awaited meeting with Downtown Development in Sydney was organized. This meeting included representatives from Ally, OSH, the police, and downtown merchants. It proved to be educational and opened doors for future communication.

- Support from police has been public including recognition that the problems faced by this population stem from health and social situations and are not criminal issues.
- Public support has been voiced for both overdose prevention and safe supply (both yet to be implemented but on the near horizon).
- Ally has initiated some discussions re how the current police funded mental health liaison officer could be more integrated into community and less based in acute care at the Regional hospital.

Relationships with Health System Partners:
Our key health system partners are basically those departments of Nova Scotia Health that are the primary point of entry to the health system for the population we serve. They include Emergency, Mental Health and Addictions (Intake, Opioid Recovery Program (ORP), In-patient withdrawal), Primary Health, and Public Health. Suffice to say, having these partners and leaders at the OSH advisory table has created a wonderful opportunity to build and strengthen relationships. On the ground we are seeing some improvement and certainly it feels as if there is a sense of hope that we can work together to make changes that will reduce stigma and lead to improved health care for this population.

Emergency:
- The relationship with Emergency has improved. The OSH nurse frequently has discussions with the clinical lead and /or other nursing staff. The OSH nurse acts as the client advocate helping the staff understand the context and complexity of client situations. There appears to be a growing awareness of OSH, and an increased understanding of the role of the OSH nurse. Ally physicians and the NP are contacting Emergency physicians to explain the context and nature of client situations and to advocate for a specific approach to care and/or for an accelerated emergency response.
- The manager of Emergency has made a commitment to continue harm reduction education that was started pre-COVID and to ensure that this education includes the local context and the role of street health.
- The manager of Emergency has expressed her concern and interest in improving the client experience at Emergency and in reducing stigma and discrimination. She is part of an Ally led working group tasked with developing an educational series targeting primary health and emergency health professionals. The goal of the working group is to provide education aimed at reducing stigma within our health system.

Mental Health and Addictions:
- Working with MHA leadership we see our relationship becoming more collegial and together we are seriously targeting some long standing issues experienced by the population we serve.
- There have been ongoing discussions re modifying the intake process to meet the needs of our most high risk and vulnerable clients. The current MHA intake process is dependent on the client making the initial phone contact and then being given an appointment time when an intake worker will call them to conduct an interview with the intake secretary. Many of the population have no phone nor do their friends or family, so the process does not work for them. Often the OSH nurse is supporting the client when they make the call and she provides her work phone number as the contact, but there is no way

of street health ensuring they can track down clients for intake appointments that are scheduled for hours or days later. OSH has been stressing the need for a "live call" intake process, meaning that if Ally is reaching out for a client and the client has no phone, then an intake is required at the time or within a very short time period.

- Further to the initial intake process described above, intake is a two stepped process for some MHA programs. If the service user can get through step one and is able to connect with an intake worker and complete the initial intake assessment then the client may be referred to a program such as Inpatient withdrawal management or Opioid recovery, for example. This second program specific intake process is also telephone dependant, and again, it is unknown when the service user may get the call for intake which of course is required for them to access that service. We are hoping to soon make progress on helping to create a more realistic intake process that suits the needs of this population.
- Street health has heightened our awareness of the seriousness of the street situation and the sheer magnitude of diagnosed and undiagnosed mentally ill people who are living on the street. We are engaged in discussions around the need to partner with MHA to imbed mental health expertise within the Ally Health Clinic.
- MHA has initiated a proposal for a .5 NP to work at the Ally Health Clinic as part of the health clinic team. This position would address some of the many needs presented by this population and strengthen our linkage with MHA. Working with the Ally physicians and NP and in collaboration with OSH, this additional service could significantly improve outcomes for many of our clients.
- OSH has identified the need for discussions around discharge planning for clients leaving the care of acute MHA. There will be an opportunity to meet with social workers from MH inpatient units to discuss how we can enhance discharge planning and communication with OSH and the Ally health clinic.
- There is agreement and a first meeting has been held to create a process for case conferencing between MHA and the Ally Health team. This process would help to coordinate the care of those clients whose situations are most complex and who are frequent users of the MHA system and the Ally Center.
- MHA has formally supported the call for sustainable funding for outreach street health, joining our primary health partners by making street health a component of their business plan for the coming year.

Primary Health Care:

- Primary Health Care has partnered with the Ally Center health clinic for several years and have responded to the identified need by providing an NP one day per week with the addition of a full time social worker 2 years ago. Primary health has been supportive of our request for increased physician sessional fee hours for the clinic, which currently stands at 12 hours per week (2 physicians each offering a 6 hour weekly clinic).
- Primary health has agreed to fund the OSH nurse position for 6 months which will extend street health from Oct 1 2021 to the end of fiscal, March 30, 2022.

- The Ally Center has received a commitment from both the Vice-President Operations Eastern Zone and from the Director of Primary Health Care Eastern Zone to seek permanent funding for the OSH nurse position. They have brought forward a formal submission to government for this funding and the VP Operations has been guiding the proposal through the process.
- A meeting was held with the manager of the Patient Flow department for the Eastern Zone to discuss how we can improve discharge planning for our vulnerable populations, particularly those who are homeless or precariously housed who have little capacity to follow up on discharge expectations. A meeting has been planned for January with the patient flow social work team.

Public Health:

- Public health has funded the OSH pilot via the Harm Reduction Implementation Team. As well, they have provided sustainable 5 year funding for the Needle Exchange and Harm reduction programming provided through the Ally Center. Needless to say, this commitment has allowed the Ally Center to truly advance the work in community. OSH is a success because it is a part of the Ally Center. It is highly doubtful that mobilizing street health would be possible without the Ally Center initiating and implementing the service.
- Understandably public health has been extremely pre occupied with managing the response to the COVID pandemic; however, OSH has reached out on numerous occasions throughout the pilot. Despite all public health staff being assigned to provincial teams and generally not being available to address local issues, local public health leadership has responded to OSH issues when necessary.
- As noted previously, the OSH nurse became a key player in assisting public health with strategies to test, assist with contact tracing, follow up and vaccination of the street population. OSH has made it clear that we are ready to assist public health in any way including offering COVID vaccination utilizing the street nurse and using our mobile supportive spaces van.

Provide primary care and facilitate access to services

The street health nurse officially began her work on the streets of the CBRM in October of 2020. The first weeks and months were about getting prepared to function as a street nurse; also about building a relationship with the Ally Center and health clinic team and getting out *on the street* to begin building trust with the population we serve. The OSH nurse began connecting with community partner agencies and their staff, introducing the general community to the street health service and assessing the street situation. Almost immediately, the street health nurse became integrated into the team and was providing primary care throughout the CBRM, working in close collaboration with the Ally Center staff, the Ally health clinic team and key community partner organizations.

The success of a street health service basically depends on the quality of the nurse/s and their ability to work autonomously in challenging situations and circumstances. It is not for the faint of heart. A street health nurse must use all nursing skills and be able to work collaboratively with a host of others including health partners, clinicians, and community agencies. Most importantly the nurse must have the skills and compassion to work with a population that is living with mental illness, substance use disorder, is traumatized, stigmatized, and

often homeless or living in deplorable situations. Entering different communities at the street level to offer services to hidden and stigmatized populations demands an approach that is respectful and that builds on the capacity of the individual and the community. The list of required attributes is many and fortunately the OSH pilot was blessed with a nurse who possessed these attributes and more. The work in turn has provided a high level of job satisfaction which is common for those who choose this work as it is truly more of a calling than a job.

After one year as a street nurse, a key role that the street nurse finds herself in is working to unravel and coordinate care for clients who have extremely complex situations; connecting with all of the players and providers involved with a client to identify what the problem actually is and how the Ally Center and health clinic can help. And/ or how the Ally Center services including OSH can complement the care the client may be receiving from other primary health care providers, services and programs.

Ensuring there is communication with the client and among providers is helping to improve overall health outcomes for clients. The street nurse is becoming that link. She states that "everyone wants to collaborate" and that they welcome her calls, her input, and her efforts to help improve the client situation. The OSH nurse's level of expertise, her experience, her approach, along with the eagerness of the providers to be flexible in order to advocate for clients is heartening.

As outlined in the previous reports, the OSH nurse has 3 levels of encounters with clients.

1) *The first level is connecting with people, saying hello, creating awareness of the OSH service and building trust.*
2) *The second level involves the OSH nurse providing services such as harm reduction education/equipment, responding to health related questions, providing supportive counselling and relapse prevention education, connecting folks with the Ally clinic, assisting with self referral to other health services, immunizing and providing anonymous testing for STBBI and testing for COVID.*
3) *The third level of encounter is when the person becomes a client of OSH and a file and client encounter form is completed. These are encounters that are significant enough to be charted by the OSH nurse.*

For the final quarter of the pilot (July to September 2021), the OSH nurse had 291 first level encounters, 70 second level encounters and 32 third level encounters. 29 of the third level encounters in this quarter were new clients added to the 49 client files that were created in the first 9 months of the pilot. During the last quarter of the pilot there were 23 referrals to social work, the Ally clinic, the foot care clinic, housing, and optometry.

What have we learned about the specific primary care services provided by the outreach street health nurse during the pilot period?

The data collection processes that were intended to capture and reflect all client encounters with OSH was somewhat of a "trial and error" for the first several months. Although we collected data from the initiation of the pilot, the approach and emphasis of what data was most important to collect was shifting. Dr. Dechman was involved early on to help create some data collection tools and the intent of those tools was

to collect the data she would be using to evaluate the pilot. With her loss, we had to re-organize. Looking to MOSH provided some help although we did not have the technology that was available to MOSH. There were however some MOSH paper charting tables that we trialed. As well, during the late summer, with the initiation of an EMR (via TELUS) for the Ally Health Clinic that includes OSH, there was a shift toward charting using EMR. This system is not as yet set up to allow us to draw down data reports specifically for OSH but we are hopeful to move in that direction over the next year.

Data collection around the 1st and 2nd levels of encounters is challenging *(connecting with people, saying hello, creating awareness of the OSH service and building trust, providing harm reduction education/equipment, responding to health related questions, providing supportive counselling, connecting folks with the Ally clinic, assisting with self referral to other health services, etc.).* These encounters are often random, happen on the street, can be multiple communications with groups of individuals etc., and it is difficult for the OSH nurse to be continually documenting throughout the day with every encounter. So we will be challenged to find an efficient way to collect such data going forward and we may need to determine how necessary it is to capture that level of quantitative data to justify the OSH work and impact. Like health care in other settings there is an assumption that a terrific amount of health care is provided in the form of education, support, navigation and referral that is never documented or calculated. Extremely important care and important to be referenced, it is however, an expected component of a health care provider's role.

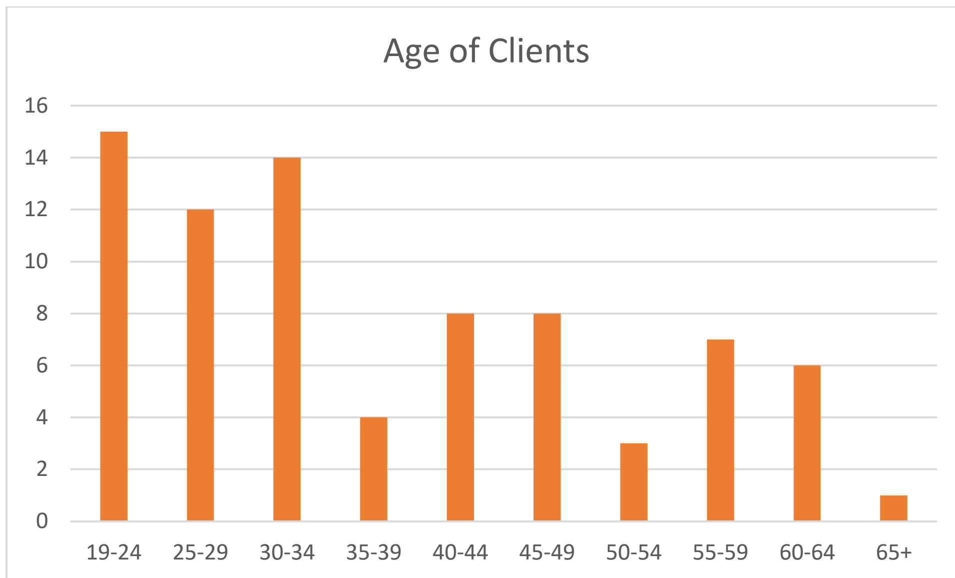
We can however provide some concrete data on those encounters.

- There has been a total of 955 COVID rapid tests performed by OSH, with the first test being offered on April 28/ 2021.
- 171 Flu vaccine administered to our population from November '20 to end of January 2021.
- 130 individuals have been vaccinated by public health at the Ally health clinic through OSH organized COVID vaccine clinics

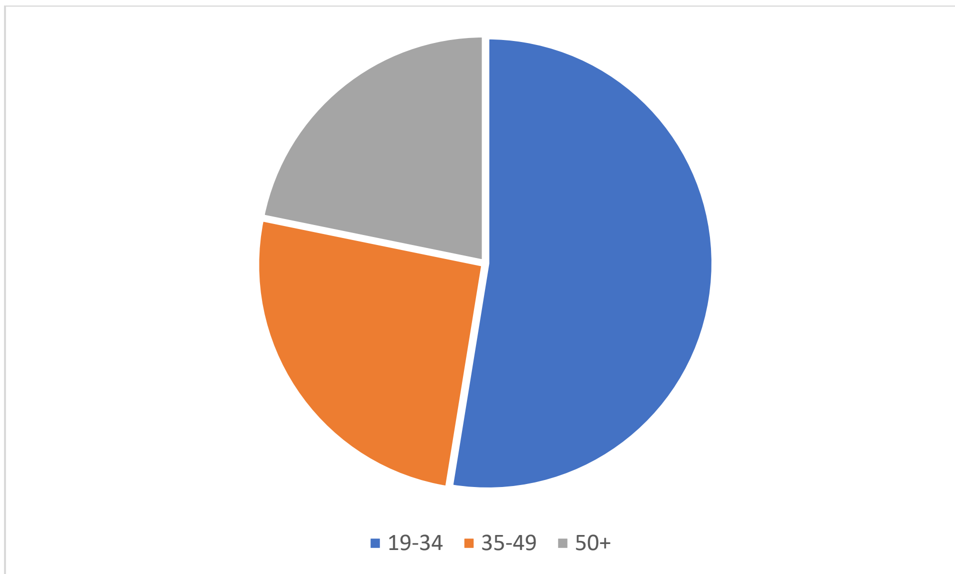
Our emphasis in reporting has been on collecting information around the 78 clients who had the 3rd level of encounter with OSH. This is when a person becomes a client of OSH and a file and client encounter form is completed. These are encounters that are significant enough to be charted by the OSH nurse.

The following graphs/charts and their descriptions give an overview of the extent and type of primary health services the OSH nurse has been involved in over the pilot period. This summary will reflect the 78 unique individuals who became "clients" of the program and who required significant support and intervention from the street health nurse. A client encounter form has been developed and used by the OSH nurse throughout the pilot to document encounters. These clients are now clients of the Ally Health Clinic although all OSH files have been filed separately for ease of access and for reporting purposes. An accompanying survey/ data collection tool was developed with the help of our MHA health promotion partners and specific information has been entered from each client file to help us create some summary findings. This data speaks to what was most relevant to help us understand the health problems faced by the street involved population in the CBRM, and the primary health care interventions provided to address those health concerns.

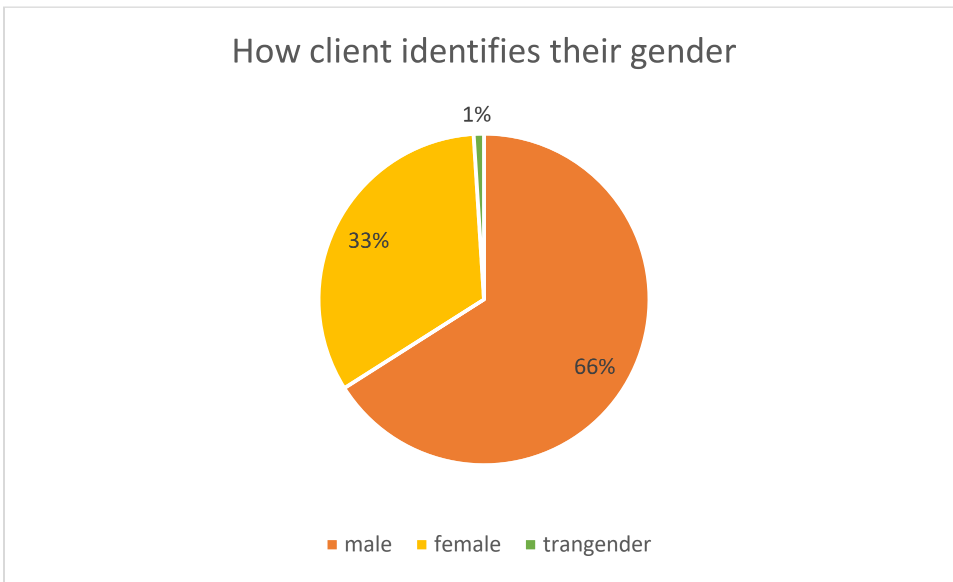
There were **78** client files created during the pilot period.



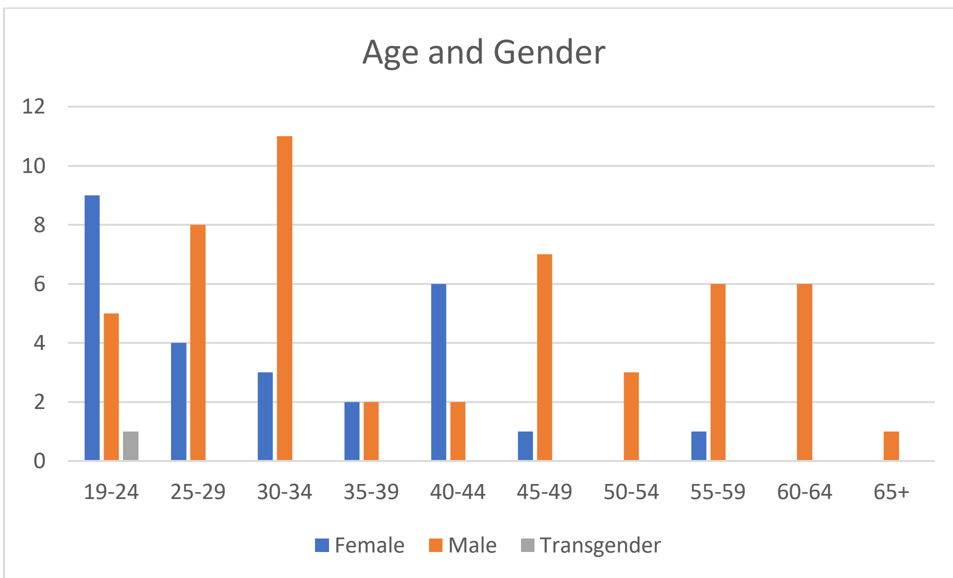
The age of the clients ranged from 19 years of age to 70 years of age.



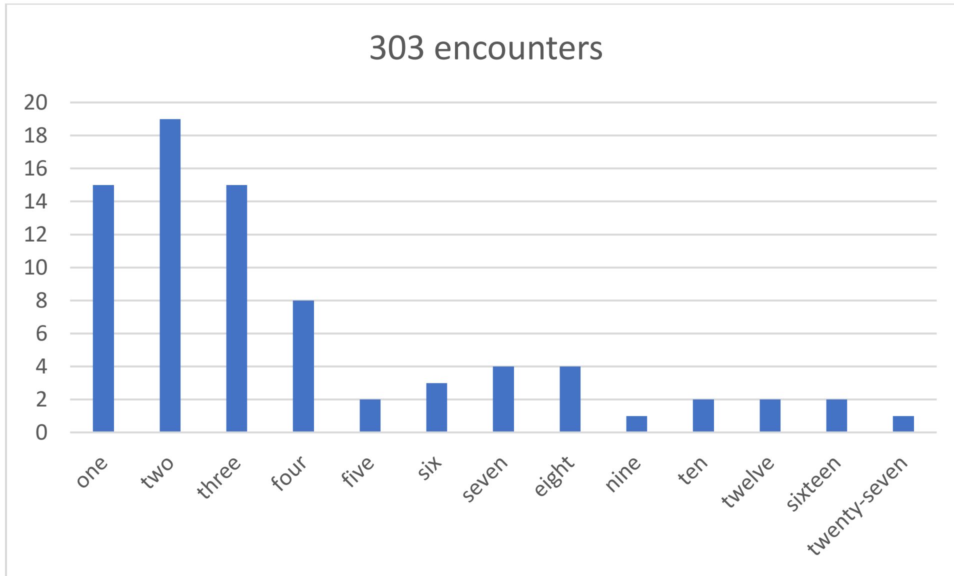
53% of clients were 19-34 yrs. age range, 26% were between 35-49 and 22% were over 50 years of age.



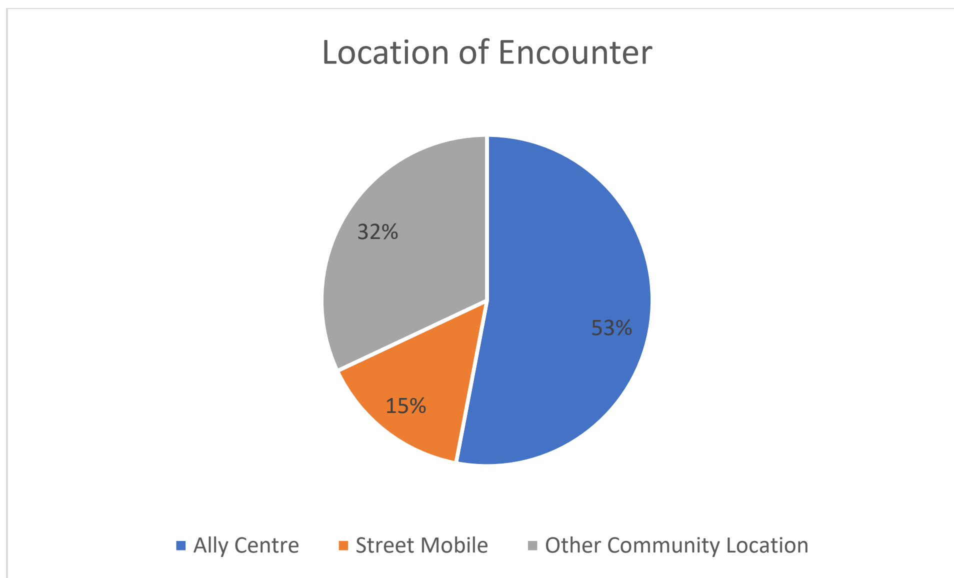
A significant majority of clients identified as male (66%), 33 % identified as female and 1% as transgendered.



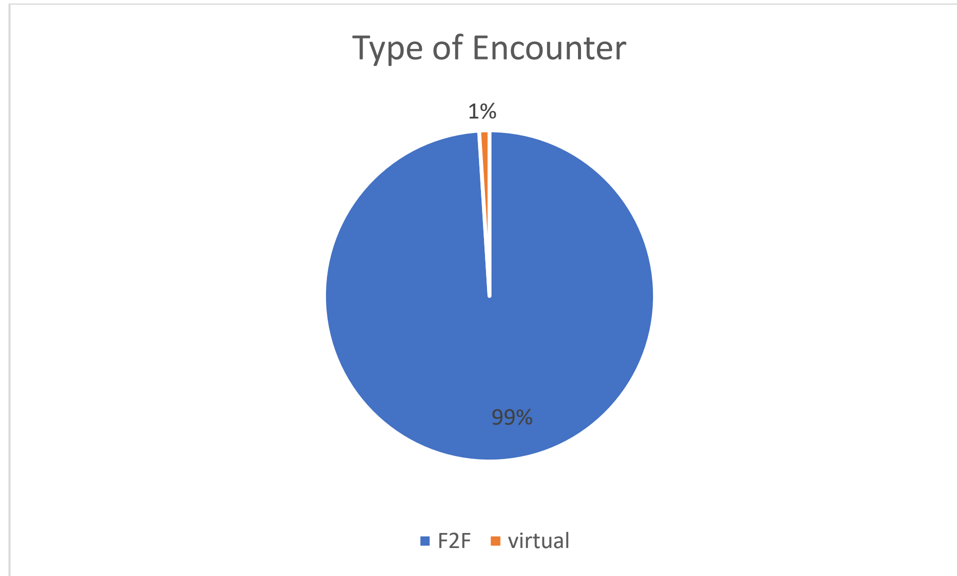
Of the youngest clients (19-24), there were more females than males engaged with street health.



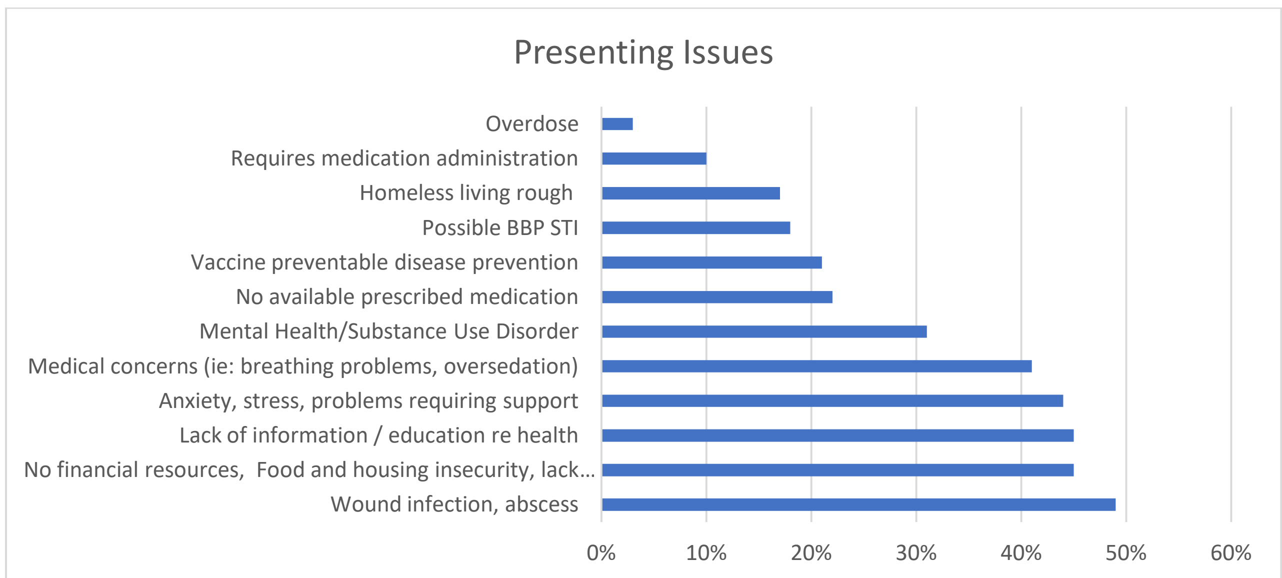
There were 303 unique encounters with the 78 OSH clients. Most clients had under 5 encounters with the street nurse, while one individual had 27 distinct health encounters with the OSH nurse.



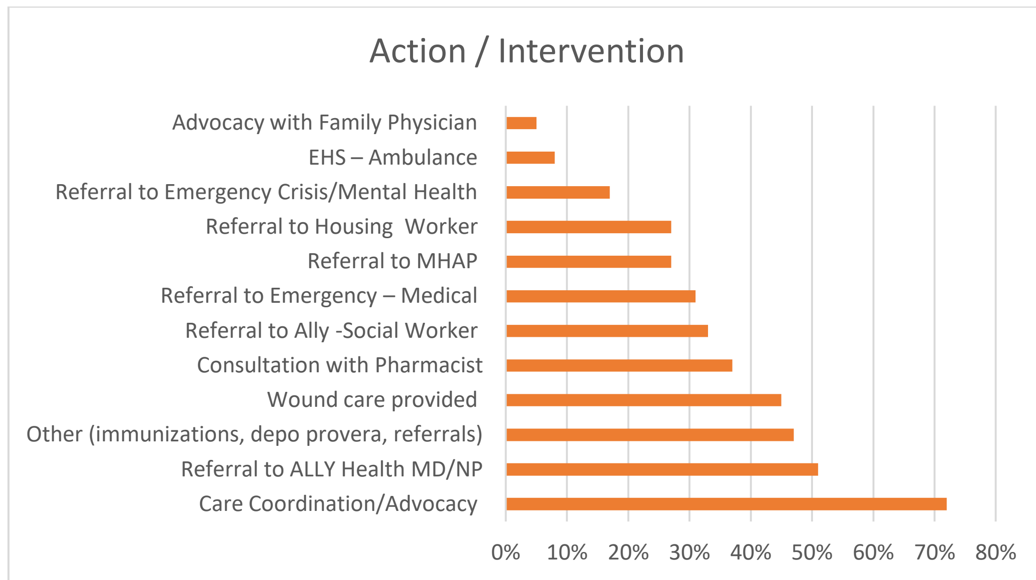
The majority of encounters (53%) with OSH for those 78 clients was at the Ally Center (this refers to in and around the Ally Center). 32% were at other community locations such as the homeless shelter and supportive housing, Loaves and Fishes soup kitchen, and "on the street". 15% were encountered when the OSH nurse was on the mobile supportive spaces van.



Practically all first encounters were face to face (99%). 33% of additional encounters (after the first encounter) were by telephone. Only 1% of encounters were virtual.
This is an interesting finding as the shift in health care as a result of COVID has been to virtual care and likely virtual care will remain as an option for many. This data indicates that the population who are most vulnerable are not likely to use or able to use virtual means to access primary health care.



Not surprisingly most clients have multiple problems that include physical and mental health and addiction problems along with social problems related to poverty, lack of housing and food, etc. The most pressing problems experienced by OSH clients were wound infections/ abscesses (50%), mental health/ stress/ anxiety, combined with a lack of information and access to resources to provide for the basic necessities of life.



The OSH nurse played a care coordination and advocacy role with over 70% of clients. Coming out of care coordination was consultation and referral/linkages to a host of health providers and services. The OSH nurse also provided direct services such as wound care, immunization/medication administration.

Planning, Development, Evaluation & Sustainability

Developmental work throughout the pilot has focused on guiding the implementation of the street health pilot by:

- Developing a one nurse street health model suitable for the CBRM
- Guiding the service implementation as it evolved month by month re approach, mobility, partnerships.
- Facilitating meetings among Ally Clinic team, Ally Center staff and OSH
- Documenting, writing updates & reports
- Media relations and meetings with community agencies and health partners
- Adapting, modifying and creating policy
- Overseeing evaluation
- Planning, chairing and follow up from advisory committee work

The one nurse model:
The goal of the pilot was to develop a model of street health that would work for the CBRM, and we were tasked to do this with minimal human and financial resources. However, the base funding for a one nurse pilot has been the critical starting point that has allowed us to test approaches, to understand the extent of the

need and to gauge our ability to deliver a street health service in a large geographic area that includes a number of small communities. Although we call it a one nurse model it is a model that actually now includes a .5 housing support worker. It also includes the contribution of peer support workers who staff the mobile van and the support of our Ally Health Clinic team, not to mention the collaboration of the Ally Center team who do harm reduction work and staff the needle exchange. So although we have only one OSH nurse, we have a team that has worked really well together and has managed to stretch the capacity of street health much beyond what any one nurse could ever do in a 4 day work week. This just speaks to the benefit of housing and providing services out of agencies like the Ally Center who have learned to do amazing things with very limited resources.
For the short term, the Ally Center sees itself continuing with the one nurse model and building our capacity as we have done with all of our programs - by using clear evidence and input from the population we serve.

Building our capacity:
We have however, learned that there is more than enough need in Sydney, at and around the Ally Center, to justify having a full time street health nurse for that area alone. And that it would be most ideal to have a second nurse work collaboratively to do outreach in outlying communities and inside organizations that are not directly in the Ally catchment area. This would very much enhance our ability to help those most at risk throughout the region. As we work to build our Ally Health clinic team to include an NP with MHA expertise and increase our physician clinic hours, we would be able to provide needed access for those most at risk throughout the CBRM.

Policies and practices:

- Policies were adapted from the MOSH program in the HRM. Their basic policies stem from the policies of the North End Community Health Center (NECHC) but over the course of their program development they have created additional polices as needed that were suited to an outreach street service. These policies were reviewed for adaptability to the Ally outreach street health service and served as a template for the development of our own policies. The willingness of the NECHC to share their policies has been a great asset and has helped the Ally Health Clinic itself get its policies in order and finalized.

Evaluation

Two external evaluators are currently writing the final draft of the evaluation report. This effort went to former colleagues of Dr. Dechman (Kirk Morrison and Marcie McKay) who had worked with her on community research projects targeting the populations we serve. We look forward to the findings from the evaluation process and thank them for their commitment to complete the evaluation for Dr. Dechman posthumously.

Sustainability

The goal for sustaining the OSH service aims to:

- Sustain the service at its current funding level, which would ensure the continuation of having one street nurse working in collaboration with the Ally Center staff and health clinic team.
- Ensure the Ally Centre continues to employ that nurse and provide the flexible, creative and supportive work environment necessary to “do” street health.

Primary Health Care Funding: A proposal was submitted to Primary Health Care to secure funding to extend OSH funding from the end of the pilot (October 2021) to end of fiscal (March 2022), with continued efforts to sustain the OSH service ongoing. As mentioned previously, through the efforts of Eastern Zone PHC partners this funding has been secured until the end of fiscal as requested and the request for permanent funding for OSH nurse position has been included in the primary health business plan for 2022. This funding and the proposal for permanent funding supports the existing model of street health specifically; the OSH nurse being employed by the Ally Center and the service being implemented through the Ally Center in partnership with the Ally Health Clinic and in collaboration with NSH partners.

The other focus of our sustainability plan is to:

- Identify tangible stakeholder contributions beyond “funds” to improve access to services in partnership with the Ally Center.
- Continue to build and strengthen relationships with key health system partners resulting in improved access to health services for the vulnerable target population.

Potential for MHA human resource contribution: As noted in 3rd quarterly report, the Ally Center has formally requested that a tangible approach to improving access for our most vulnerable would be to contribute MHA expertise to the Ally Health Clinic team of providers. Almost 100% of the population served by the Ally Center are living with mental illness and/or substance use disorder. As well, the Ally clinic frequently receives referrals from MHA for clients requiring complex care, with no prescribing physician or provider. The current physicians and NP who provide health services at the Ally clinic have identified the challenges they encounter with many of the clients who currently suffer from mental illness. There are medication and prescribing issues, concerns around access and linkages with MHA services such as psychiatry, therapists/ counsellors, etc. and a need for more thorough consultation and support for the providers themselves. An NP with the background and MHA connections could greatly improve the approach and streamline services for this population resulting in benefit for all involved. Our request to MHA leadership included a request for a Nurse Practitioner from MHA to provide 6 clinic hours per week at the Ally Health Clinic. There have been several discussions with the Eastern Zone MHA Director and the Senior Provincial Director of Mental Health and Addictions re the needs and potential benefits of this approach.

- The gravity of the situation seems to have been acknowledged and we are excited to report that MHA leadership have submitted a proposal to NSH to fund a Nurse Practitioner position; .5 of that FTE would involve them working collaboratively with the Ally Health Clinic.

Other funding and in kind sources: The additional cost to operate the outreach street health services at its current level requires at least $36,000 in additional funds. These funds come from in kind and other funding sources. We have received funds from Reaching Home to take us to the end of fiscal (March 30 2022). As well, the CBCHA Director has agreed to extend the .5 housing support worker to end of fiscal and beyond, as long as OSH continues to be funded. Having the OSH nurse position permanently funded is the leverage required for other programs to step up and contribute. The potential and hope is that we can build a street health service that has a full complement of appropriate service providers similar to our MOSH partners in the HRM.

Community Support: We are confident that our community partner agencies are ready to support our sustainability through in kind contributions and partnerships that enhance the service. As well, we recognize the strength of their voices to advocate for the continuation of street health if required. The public has become increasingly aware of the street health service and we are comforted to know they would be willing and ready to respond to our request for financial support and advocacy if required. We have received some significant donations from citizens directed specifically toward street health and we are frequently asked how street health can be supported.

Advisory Committee:

The accountability expectations from the funders included *the development of an advisory group of key stakeholders to advise on the development, evaluation and sustainability of a mobile outreach street health program.* This expectation provided a concrete purpose and unique opportunity to bring key leaders and decision makers together.

The following individuals/ organizations are the Advisory members for the OSH pilot:

- MOSH Lead, North End Community Health Centre, HRM (Becky Marval)
- Mental health and addictions (Eastern Zone Director, Nadine Wadden)
- Public health services (Eastern Zone Director, Marc Arsenault)
- Primary Health Care (Eastern Zone Director, Kathy Bell)
- Emergency services (Manager, Barb O'Niell)
- Tui'kn Partnership (Stacey Lewis)
- Correctional Services (Gena MacDermid)
- Cape Breton Community Housing (Director, Fred Deveaux)
- Primary Care Physician (Dr. Meaghan Keating)
- Ally Centre Board (Margaret Dechman Phd) – Deceased, November of 2020
  - Replaced by Peter Littlejohn, former family physician and Ally Board Member
- Ally Centre Staff (Christine Porter, Director; Janet Bickerton RN, Health Services Coordinator; Sharon MacKenzie RN, Outreach Street Health Nurse)

With the exception of the Correctional Services representative, the primary care physician and public health (due to COVID demands), all other advisory members regularly attended the advisory meetings. There were 7 advisory meetings held during the one year pilot period, and an 8th meeting held most recently in December of 2021. Most heartening is that the committee and its members have decided to continue in their advisory capacity. They have agreed that the committee has been fruitful and that its continuation would be a good use of their time.

The terms of reference developed by the committee were broad and exploratory. In developing these terms we were aware that this was the first opportunity for these specific health departments and community partners to come together for dialogue and that the problems we were asking them to explore were complex. Therefore it was important that we create a safe space and take the time to learn from each other.

The terms of reference for the advisory committee:

- To advise on the mobile outreach street health program development, evaluation, and sustainability.
- Develop a collaborative approach to explore the improvement of services for vulnerable populations.
- Explore stakeholder roles in service delivery.
- Explore stakeholder roles in sustaining the outreach street health service.
- Explore data sharing opportunities.

As noted earlier in this report, having these partners and leaders at the OSH advisory table has created a wonderful opportunity to build and strengthen relationships. A result is that "on the ground" we are seeing some improvement and it certainly feels as if there is a sense of hope that we can work together to make changes that will reduce stigma and lead to improved health care for this population.
We believe a factor in the relationship, along with good will and a true recognition of the seriousness of the problems "on the street", is that the Ally Center brings with it a complement of staff and representatives with "street credentials", several who also have previously worked in leadership roles in the health system. They understand how the system functions and the frustrations that can go with trying to create change from the inside. We are just beginning our journey together but there is mutual respect and acknowledgement that by working together we can contribute to improving the experience and the health outcomes for clients.

During the last quarter of the pilot, the OSH advisory group of key stakeholders met on September 2nd with an additional meeting on December 8th. We can say with confidence that the advisory meetings have brought the most pressing concerns regarding access to the health system and the seriousness of the street situation to the consciousness of those at the advisory table. We see evidence that these discussions and the opportunity to explore together have resulted in strengthened collaboration, not only between the system and key community agencies like the Ally Center, but among and between departments inside NSH. Below are some recent key discussions and initiatives:

- The Advisory committee continued to explore stakeholder roles, and to discuss gaps, challenges and barriers to accessing services. There are regular updates regarding the street situation, the activities of the street health nurse and relevant developments at or through the Ally Center such as the plans for the operation of an Overdose Prevention site and the efforts to secure safe supply. These are critical community developments that our health partners should be aware of and their seat at the OSH advisory table has provided that opportunity.
- The committee reviewed progress on the external evaluation and discussed how the OSH evaluation report might be utilized. Ideas included using the findings for a meeting with the new Minister for Mental Health and Addictions, Brian Comer MLA. This meeting was then organized by Advisory member Fred Deveaux and was attended by CB Community Housing Director, Fred Deveaux; Ally

Director, Christine Porter; Ally Health Services Coordinator, Janet Bickerton; Senior Director MHA, Samantha Hodder; and Minister of MHA, Brian Comer. The discussion was focused on the need for street health to continue and around the need for more MHA services to be located in community, imbedded in organizations that are providing services to the vulnerable population. A follow up summary letter with identified actions was requested and forwarded to Minister Comer.

- Advisory member Stacey Lewis from the Tui'kn Initiative organized a meeting for our First Nation Health partners and the Ally Center/OSH team. Valuable information was shared regarding how both can best support and provide services for indigenous people who are living on or off reserve and are using the services of the Ally Center.
- Reducing the stigma and discrimination that is inherent in the health system is a concern that has been discussed throughout the advisory meetings. A planning group has been formed to develop initiatives aimed at reducing stigma. This group is chaired by advisory member Peter Littlejohn and includes another advisory member (Manager of Emergency, Barb O'Neill) along with staff from MHA and the Ally Center. A trial monthly educational webinar series for primary care providers is planned to begin in February of 2022. They are hoping this series will also provide an opportunity to alert care providers re current situations in community such as street drug alerts.
- MHA Eastern Zone Director and Emergency Manager have met to discuss the continuation of harm reduction education. As well, the Emergency Manager will be attending the MHA public advisory group meeting giving the public an opportunity to listen and share their concerns re the experiences of those utilizing Emergency to attempt to access mental health and addiction care.
- As detailed earlier, the ongoing discussions at the advisory table regarding the seriousness of mental illness and concerns re access to MHA for our population have resulted in some steps toward tangible services to be offered in community in partnership with the Ally Health Clinic.
- Funding to extend the OSH nurse position for 6 months has been secured and received by the Ally Center and a permanent funding request is in the PHC business plan for '22-'23. The MHA Director confirmed that MHA supported this request along with PHC recommending OSH as a permanent component of the service plan going forward.
- Data sharing is challenging however the purchase of an EMR system for the Ally Health Clinic that includes the OSH nurse as a provider now allows for immediate documentation and sharing of information among the Ally health team. It does not however include those who do not work directly for NSH. So although the OSH nurse can share among the health team at Ally, she cannot be privy to NSH information on any clients, which of course leaves client care fragmented. Learning from our advisory members, our First Nations health partners experience the same issues at their health centers where FN health staff cannot access any NSH information on the clients they are caring for. As well MOSH is in the same situation. There is opportunity for more discussion as to how we can think about information sharing and broadening the circle of care such as becoming *custodians* as some FN health partners have done. However, another example of data sharing is the development of a process for case conferencing between MHA and the Ally Health Clinic. This is a very big step toward sharing of information to benefit client care. We are hopeful that these initial steps will prove to be positive for both providers and ultimately will result in improved health outcomes for our shared clients.