Mobile and Outreach Service Mapping:

A Current State Analysis of the Greater Hamilton Health Network Service Areas 2024

Completed May 2024 by
Starling Strategic Consulting on behalf of the Greater Hamilton Health Network

Greater Hamilton Health Network

Building community health together.

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Executive Summary

1.0 Introduction

1.1 Purpose and Rationale

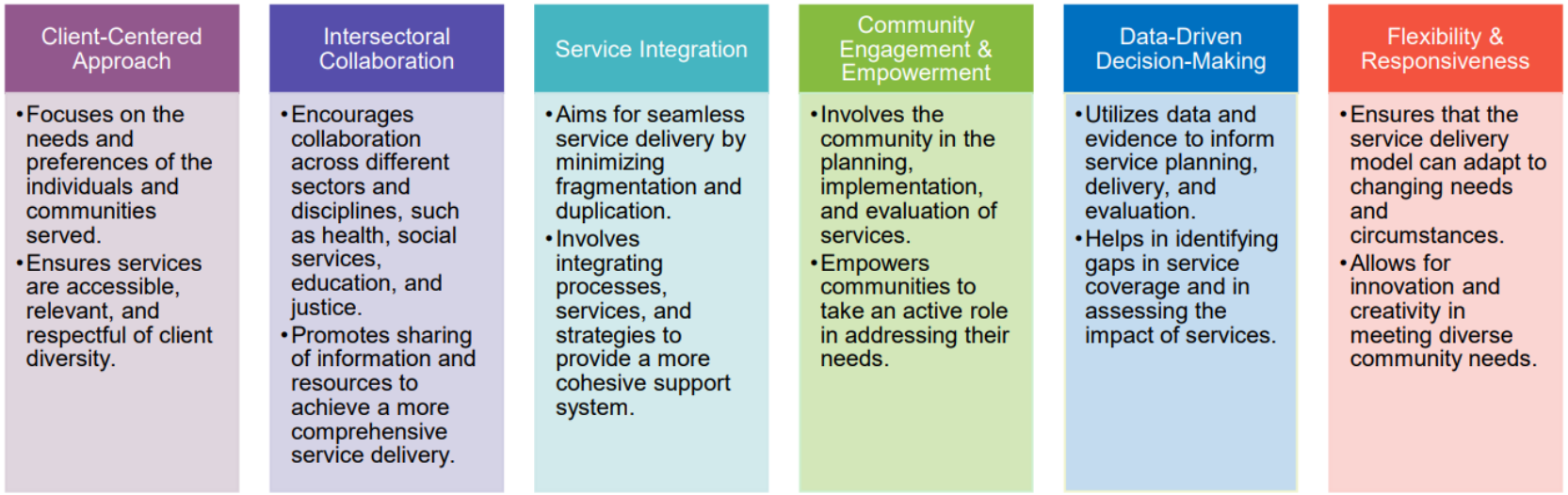
The Greater Hamilton Health Network (GHHN) is committed to enhancing healthcare and social service delivery within Hamilton, Haldimand, and Niagara Northwest through focused initiatives on mobile and outreach services. Within the framework of Ontario Health Teams (OHT) introduced by the Ministry of Health, this project aims to foster patient-centered, integrated care across various sectors. Addressing the inefficiencies observed due to fragmented service provision—such as duplication and resource wastage—is particularly crucial for marginalized and disadvantaged populations who are most affected.

1.2 Data Collection Methods, Inclusion/Exclusion Criteria

Our data collection methodology is built upon a rigorously defined taxonomy that ensures consistent categorization and clarity of mobile and outreach services. The inclusion criteria target services that are geographically within the GHHN, actively offered at no or subsidized cost, and provided consistently. Services not directly related to primary healthcare or critical social support, such as legal or educational services, are systematically excluded to sharpen the focus on immediate care needs.

1.3 Theoretical Foundations

Grounded in the Integrated Service Delivery (ISD) Framework, our analysis advocates for seamless coordination across healthcare, social services, and community support. This framework is instrumental in addressing complex social health issues, promoting an integrated approach that minimizes service fragmentation and enhances delivery effectiveness, particularly for those underserved by traditional models. Below is a visual representation of the IDS Framework.



1.4 Importance and Limitations of Current State Analyses

While current state analyses are invaluable for strategic planning and resource allocation, they inherently capture only a snapshot of existing conditions at a single point in time. This analysis provides a baseline from which to measure progress and identify gaps; however, it is crucial to recognize that sustaining improvements requires continuous monitoring and an adaptive response system. Without these mechanisms, the momentum gained from initial findings and subsequent interventions risks stagnation, failing to evolve with changing community needs and healthcare dynamics.

1.5 Conclusion

The current state analysis conducted by the GHHN serves not only as a diagnostic tool but also as a strategic foundation for future advancements in service integration. By focusing on enhancing mobile and outreach services, the GHHN is taking significant steps towards creating a healthcare environment that is responsive, equitable, and effective for all community members. Moving forward, it is essential that this effort is supported by ongoing assessments and flexible strategies that respond to new challenges and opportunities, ensuring that the health outcomes for all populations, regardless of their socioeconomic status, continue to improve.

2.0 Data Collection and Definitions

2.1 Service Providers

A total of 24 unique service providers were identified during the scan. It should be noted that there are likely other services offered to the specific populations explored in this mapping project, but they did not meet the explicit inclusion criteria required for the outreach & mobile health services analysis (see Phase 1 report).

For services to be included in the service mapping, they had to be:

- Within the geographic boundaries of the Greater Hamilton Health Network,
- Offered free of cost or subsidized through eligibility to be free of cost,
- Offered currently (i.e. not closed or on hold),
- Offered with some consistency,
- Providing at least one of the identified clinical services (,
- Providing services to at least one of the identified priority populations.

Below is a breakdown of the service providers and the GHHN geo-region they provide service(s) in:

Haldimand [NOA, N1A, N3W]	1. Community Addiction and Mental Health Services of Haldimand and Norfolk - Addiction Mobile Outreach Team (AMOT) 2. The AIDS Network - Hamilton & Haldimand 3. Brant Haldimand Norfolk RAAM Clinic
Hamilton [L8B, L8E, L8G, L8H, L8J, L8K, L8L, L8M, L8N, L8P, L8R, L8S, L8T, L8V, L8W, L9A, L9B, L9C, L9G, L9H, L9K, L0R, L0P, N0B, N1R]	1. CMHA Street Team, Peer Support Services Outreach & MH Navigator, RIST; Canadian Mental Health Association, Hamilton Branch 2. St Matthew's/City of Hamilton - Housing Focused Street Outreach 3. De dwada dehs nye>s Aboriginal Health Centre Mobile Medical Clinic 4. Good Shepherd Health on Wheels Mobile Health Clinic 5. Hamilton Midwives Outreach Team 6. HAMSMaRT / Keeping Six 7. Wayside House of Hamilton - HepC Outreach Team 8. Hamilton Health Sciences - Hospital 2 Home 9. Hamilton Regional Indian Center - Mobile Street Outreach 10. Hamilton Police Service - Social Navigator Program(SNP) & Rapid Intervention and Support Team (RIST) 11. The Hub - Street Outreach Clinics 12. City of Hamilton Public Health Services - Harm Reduction Program 13. City of Hamilton Public Health Services - Mental Health and Street Outreach Program 14. Good Shepherd RAAM - Mobile and Community-Based Program

	15. St. Joseph's Healthcare Hamilton - Hospital 2 Home 16. Wesley - Provincial Youth Outreach Workers Hamilton/Brantford 17. YWCA Emergency Reproduction Care - Mobile 18. Shelter Health Network 19. The AIDS Network - Hamilton & Haldimand*
Niagara Northwest [LOR, L3M, L0S, L3J]	1. Niagara Region Assertive Street Outreach Team 2. Positive Living Niagara 3. Niagara Region Outreach Nurses

*The AIDS Network of Hamilton & Haldimand is listed in both geo-regions but only counts as one service provider in the overall list. This is the only service provider repeated in the breakdown above.

2.2 Services Offered

The following list of services was developed during the scoping phase of the project and was agreed upon as part of the inclusion and exclusion criteria. It is divided into clinical services and social care services. To be included in the service mapping, providers needed to offer at least one of the clinical health services listed.

Type of Service	Included Services	Excluded Services
Clinical Health Services	- General Health Services: Basic health check-ups, treatment of common illnesses, and ongoing health monitoring. - Contraception and Sexual Health: Providing birth control, STI/HIIV testing, and sexual health education. - Wound Care and First Aid: Managing minor injuries and providing first aid.	- Pediatric Services: Healthcare services focused on the needs of children and adolescents. - Geriatric Care: Tailored health services for elderly populations. - Dental Care: Basic dental services and emergency dental care.

	- Chronic Disease Management: Services for long-term conditions like diabetes, heart disease, and asthma. - Mental Health and Counseling: Mental health assessments, therapy, and support for mental health issues. - Substance Use Treatment: Treatment and support for substance abuse disorders, including counseling and rehabilitation. - Preventive Care and Screenings: Immunizations, health screenings, and preventive health advice. - Maternal and Reproductive Health: Prenatal, maternity, and postnatal care, along with reproductive health services. - Gender-Affirming Care: Healthcare services that support gender identity, including hormone therapy and psychological support. - Linking/ bridging to clinical services/providers.	- Vision and Hearing Services: Eye and hearing tests, provision of glasses or hearing aids. - Nutrition and Wellness: Nutritional advice, wellness programs, and lifestyle counseling.
Social Care Services	- Wraparound Mental Health Service Referral: Directly connecting individuals with mental health professionals and services that cater specifically to the needs of people in encampments and shelters. - Food Provision and Nutritional Support: Directly providing food to clients during service delivery. Also includes collaborating with local organizations to ensure the regular provision of food supplies and nutritional education in encampments and shelters. - Housing and Shelter Assistance: Working closely with housing authorities and shelter systems to secure emergency and stable housing solutions and advocate for the rights of individuals in temporary accommodations. - Employment and Education Support: Facilitating access to job skill-building and	- Legal and Advocacy Services: Legal advice, representation, and advocacy on issues like housing rights, immigration, and civil rights. - Crisis Intervention and Safety Services: Immediate response services for crises such as domestic violence, mental health emergencies, and natural disasters. - Educational Services: Literacy programs, skill development workshops, public health education, and community awareness campaigns.

	educational materials tailored to the unique circumstances of individuals. - Social Welfare Services: Providing personalized assistance in navigating and accessing social welfare programs. - Linking/bridging to social care services/providers.	

2.3 Populations of Interest

Key service users/target audiences for this current state analysis were determined to be:

- Encampment Residents: Tailored services for individuals living in temporary or informal housing arrangements.
- Women and Gender Diverse Populations: Services that are inclusive and sensitive to the needs of transgender, non-binary, and other gender-diverse individuals.
- Individuals with Limited Access to Healthcare: Outreach to people who are typically underserved by the mainstream health system, including those who are unattached to primary care providers.
- Men Involved in the Shelter System: Services that aim to reach men who are served through shelters or other outreach touch points.
- Youth and Young Adults: Primary target of outreach and mobile service is youth and young adults up to the age of 24.

Excluded Population Group - General Public: Services designed for the broader community and for those who can access health and social services through more traditional system pathways.

2.4 Service Delivery Models

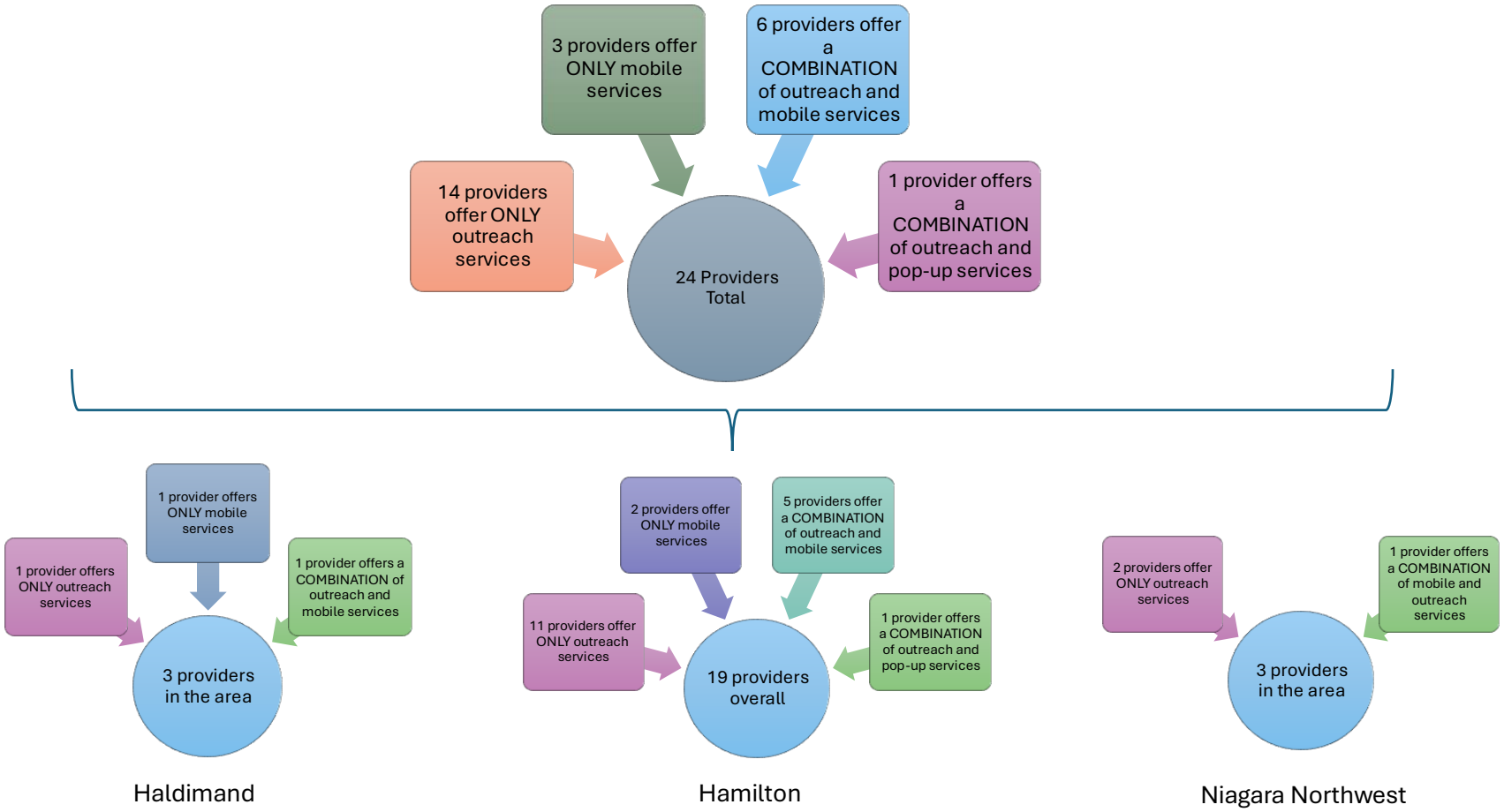
The specific delivery model options this project looked at were:

- Mobile: Services delivered through vehicles or movable clinics that travel to various locations to provide medical care. These units are equipped with necessary medical equipment and staff to offer a range of healthcare services. They have a scheduled route or set locations they visit regularly, providing consistent access.
- Outreach: Specialized services where outreach professionals proactively engage with populations residing in specialized settings such as encampments, shelters, and other non-traditional care environments. These services are tailored to address the unique health needs and challenges faced by individuals in these settings, providing direct access to care, resources, information, and support.
- and to some extent, pop-ups: services are temporary setups that operate for a short duration, ranging from a few hours to several days, in a particular location. They are set up in various environments and are more likely to be event-driven or need-based, focusing on specific needs like flu vaccinations, health screenings, or health awareness events than consistent service delivery.

Excluded service delivery models were:

- Door-to-Door Outreach: Direct delivery of services to individuals' homes, especially beneficial for those who are homebound or in remote areas.
- Community-Based Approach: Utilizing local community centers, schools, or other communal spaces to provide services.
- Digital/Remote Services: Offering services via online platforms, telehealth, and other remote communication technologies.

Below is a breakdown of the service delivery models across the GHHN catchment areas (note that one provider offers services in both Hamilton and Haldimand and is counted in both regions):



2.5 Service Access Models

The service access models that were explored in this current state analysis included:

- **Direct Access Services**: Services that individuals can access without any referral. These are typically designed to be easily accessible to the target population. Examples include walk-in clinics, mobile health units in public spaces, and most community-based support services.
- **Referral-Based Services**: Services that require a formal referral from a healthcare provider, social worker, or other professional or agency. These services are often more specialized or resource-intensive and may include certain types of mental health services, specialized medical treatments, or access to certain shelters or housing programs.
- **Self-Referral:** Clients can self-refer or register for services as needed without the input of a health or social care partner.

2.6 Partnership Models

The following partnership models were used to collect data for this current state analysis:

- **Cross-Sector Collaborations**: Partnering with various sectors including healthcare providers, non-profits, educational institutions, and businesses.
- **Community and Grassroots Involvement**: Engaging with community groups, local leaders, and volunteers for a more community-driven approach.
- **Public-Private Partnerships**: Collaborations between government bodies and private organizations for resource sharing and joint initiatives.

2.7 Funding Sources

The following funding sources were included in the data collection for the current state analysis:

- **Diversified Funding Sources**: Combining funding from government sources, private donors, and non-profit organizations. ·
- **Targeted Funds for Special Populations**: Allocating specific funds to address the needs of targeted groups such as the homeless or gender-diverse populations.
- **Community Sponsored**: Relying on local community groups and grassroots fundraising efforts for support.
- **Publicly Funded**: Financial support provided by government sources at the local, state, or federal level, typically allocated through taxes or other public revenues to support services and projects benefiting the general public.

2.8 Metrics of Success

The following data were collected to determine how providers of mobile and outreach services are measuring their success:

- **Feedback from Diverse Populations**: Gathering and analyzing feedback to ensure services meet the diverse needs of the community.
- **Service Utilization and Reach Metrics**: Monitoring how widely and effectively the services are being utilized.
- **Impact on Community Health and Well-being**: Evaluating the long-term effects of services on community health, social stability, and overall quality of life.

3.0 Findings

3.1 Haldimand's Story

Summary: Service Provision in Haldimand

This report provides a current state analysis of the healthcare and social service landscape in Haldimand as part of a broader initiative by the GHHN to improve service integration for marginalized populations.

Key Findings:

Service Gaps: There are notable deficiencies in essential services such as general health, wound care, chronic disease management, and gender-affirming care. These gaps indicate potential areas where services are either non-existent or not delivered through accessible mobile or outreach methods.

Operational Strengths: Despite the identified gaps, there is a strong foundation in addressing mental health, substance use, and communicable diseases. These strengths demonstrate a commitment to addressing some of the most pressing health issues in the community.

Staffing and Resource Allocation: Challenges in staffing, particularly in filling all budgeted positions, suggest issues with recruitment or resource allocation that could impact service delivery.

Partnerships and Collaboration: Effective collaborations are in place to enhance the delivery of comprehensive and holistic care, although a lack of detailed data on partnerships for some providers limits a full understanding of the collaborative network.

Strategic Recommendations:

1. **Broaden Service Coordination:** Address the significant service gaps by exploring opportunities to coordinate, integrate, or expand services in underrepresented areas such as general healthcare and preventive care.
2. **Strengthen Staffing Strategies:** Explore robust recruitment strategies to ensure that service capacity meets community needs.
3. **Expand Collaborative Networks:** Build on existing collaborations to further connect services and ensure a seamless care pathway.

3.1.1 Who's Doing What?

An analysis of the types of healthcare and social services offered by the providers in Haldimand is outlined in the tables and summary below. Note: **Only one of three** service providers (AMOT) validated their information, so the data on services are based on what was publicly available.

Provider Name	General Health Services	Contraception Family Planning	Wound Care	First Aid	Chronic Disease Management	Mental Health and Counseling	Substance Use Treatment	Preventive Care and Screenings	Maternal and Reproductive Health	Immunizations	Gender-Affirming Care	STI /HIV testing	STI/HIV treatment	Harm Reduction Supply Distribution	Linking/Bridging to Clinical Services
Community Addiction and Mental Health Services of Haldimand and Norfolk - AMOT						x									x
Brant Haldimand Norfolk RAAM Clinic						x	x							x	x
The AIDS Network - Hamilton & Haldimand		x									x	x	x	x	x

Table 1: Healthcare services offered by providers. Note: One provider (AMOT) added that they also offer problem gambling and concurrent disorder support services.

Provider Name	Wraparound Mental Health Service Referral	Food Provision and Nutritional Support	Housing and Shelter Assistance	Employment and Education Support	Social Welfare Services	Linking/Bridging to Social Services
Community Addiction and Mental Health Services of Haldimand and Norfolk - AMOT	X		X			X
Brant Haldimand Norfolk RAAM Clinic	X					X
The AIDS Network - Hamilton & Haldimand						X

Table 2: Social services offered by providers.

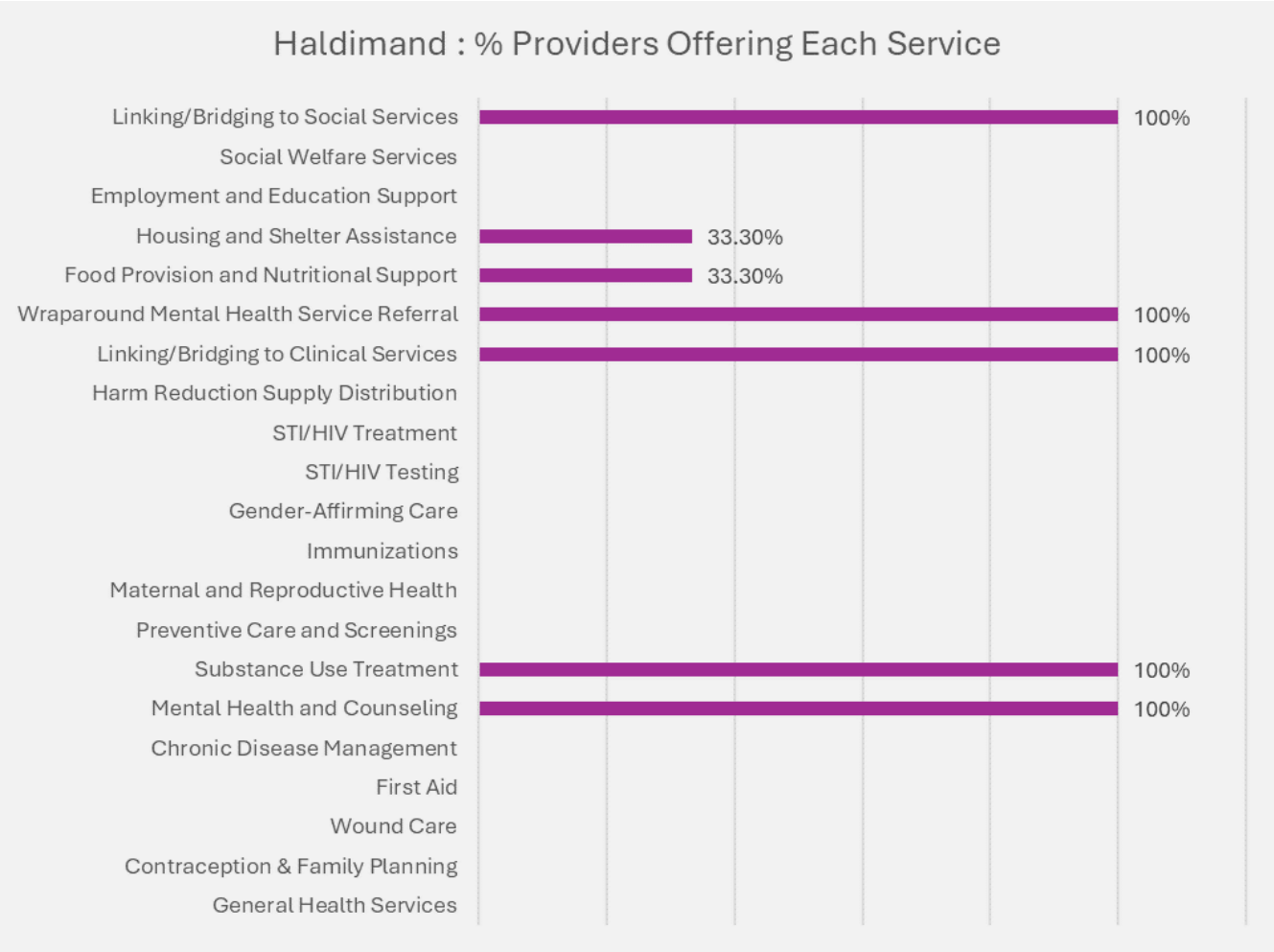


Chart 1: Percent of Haldimand providers offering each service.

Service Offerings Data Interpretation:

Gap Analysis - The service provision assessment in the Haldimand region, focusing on the three providers that met the inclusion criteria, reveals a limited range of available services. Notably missing are:

- General Health Services

- Wound Care
- First Aid
- Chronic Disease Management
- Preventive Care and Screenings
- Immunizations
- Maternal and Reproductive Health
- Gender-Affirming Care

The absence of these services may indicate a gap in service provision overall, or it may suggest that these services are available elsewhere in the region but not delivered through mobile or outreach providers, which are essential for reaching underserved populations.

Current Strengths - The three providers showcase significant strengths, addressing critical community health needs:

- Mental Health and Counseling: Reflective of a community-centric approach to prevalent mental health and addiction issues.
- Substance Use Treatment: Demonstrating a focus on urgent needs in mental health and substance use.
- STI/HIV Management and Harm Reduction: Highlighting proactive measures in communicable disease control and safe practices.
- Linking/Bridging to Clinical and Social Services: Indicating an integrative model that ensures access to a wider spectrum of necessary medical and social care.

Strategic Implications and Additional Considerations – The findings suggest a strategic need for integrated service models and community-based health initiatives, particularly in areas lacking direct service provision. Enhanced collaboration is crucial for filling service gaps and improving access, especially through outreach and mobile services aimed at underserved populations in Haldimand.

3.1.2 Who's being served?

An analysis of the priority populations eligible to access the mobile and outreach-based services in Haldimand is outlined in the table and summary below.

Provider Name	Encampment Residents	People who use substances or experiencing addiction	Women and Gender-Diverse Populations	Individuals with Limited Access to Healthcare	Youth and Young Adults (up to 24 years old)	Men in the shelter system
Community Addiction and Mental Health Services of Haldimand and Norfolk - AMOT	X	X	X	X	X	X
Brant Haldimand Norfolk RAAM Clinic	X	X		X		
The AIDS Network - Hamilton & Haldimand	X	X	X	X	X	X

Table 3: Priority Populations Served in Haldimand. Note: One provider (AMOT) noted that they also offer services to people experiencing problem gambling but that all services, for all population groups require self-determination and readiness for change.

Service Users	Percent of Hamilton Providers Serving Each Population
Encampment Residents	100%
People who use substances or experiencing addiction	100%
Women and Gender-Diverse Populations	66.7%
Individuals with Limited Access to Healthcare	100%
Youth and Young Adults (up to 24 years old)	33.3%
Men in the shelter system	66.7%

Chart 2: *Percent of Haldimand providers who serve each priority population group.*

Data Interpretation of Populations Served:

In the Haldimand region, service providers cater to a wide spectrum of target populations, each with distinct health and social needs that mirror the diverse challenges faced by these groups. Providers such as AMOT and The AIDS Network are committed to offering holistic and inclusive models of care. This ensures that everyone, regardless of their specific circumstances, has access to the health services they need. This inclusivity is particularly crucial in Haldimand's rural settings, where service availability and accessibility can often be limited.

Conversely, the RAAM Clinic has adopted a more focused strategy, concentrating on addressing substance use. This targeted approach prioritizes resources towards high-need populations, which is essential for effective community health management. Across all services, there's a strong emphasis on empowerment through self-determination. This philosophy respects individual autonomy and recognizes that successful health outcomes are often closely linked to a person's readiness and willingness to engage in their health journey.

These observations **underscore the necessity for broad-based service models** that can adapt to and effectively address the diverse range of health and social needs in Haldimand. Continuous assessment and adaptation are also highlighted as crucial components. As the community's needs evolve and new health challenges arise, it's vital that service models remain flexible and responsive.

In summary, the healthcare and social service landscape in Haldimand showcases both the challenges and opportunities inherent in delivering care to a diverse and often underserved population. The overarching focus on empowerment and readiness for change underscores a progressive approach to healthcare, one that highly values patient engagement and aims for holistic well-being.

Cross-Tabulation Summary of Healthcare and Social Services in Haldimand:

Community Addiction and Mental Health Services of Haldimand and Norfolk - AMOT	Offers a broad array of services including mental health counseling, substance use treatment, STI/HIV testing, harm reduction, and linking/bridging to clinical services, catering to diverse populations such as encampment residents, individuals with substance use issues, and youth. Additionally, it provides housing assistance and comprehensive social services referrals.
Brant Haldimand Norfolk RAAM Clinic	Focuses on mental health and substance use treatment, STI/HIV testing, and harm reduction, primarily serving encampment residents and individuals with substance use issues. It also offers mental health service referrals and links to social services, but its service range is more limited compared to other providers.
The AIDS Network - Hamilton & Haldimand	Offers the most extensive service range, including general health services, family planning, mental health counseling, substance use treatment, preventive care, gender-affirming care, and STI/HIV treatment. It serves all targeted populations and provides social service linkage similar to other organizations.
Key Observations: • **AMOT** and **The AIDS Network** stand out for their comprehensive healthcare and social care services available to all listed populations. • **The AIDS Network** is notable for its inclusive health services like general health and family planning, which other providers do not offer. • **RAAM Clinic** displays a more focused service range and lacks specific services for women, gender-diverse populations, and individuals with limited healthcare access.	

Strategic Recommendations:

This analysis highlights the need for enhanced service coordination and integration across providers to effectively address gaps without requiring unrealistic expansions of individual services.

- **Enhanced Coordination**: Develop a coordinated service model that leverages the strengths of existing providers. This model might involve clear protocols for referrals and shared care plans, ensuring that patients can seamlessly access a comprehensive array of services across different organizations.
- **Collaborative Networks**: Continue to strengthen networks among providers to facilitate a system of wrap-around services. By enhancing collaboration, each provider can focus on their specialty while still ensuring that collectively, all patient needs are met efficiently. This could include regular communication forums, shared training sessions, and joint funding applications to increase overall service capacity.
- **Policy Advocacy**: Advocate for policy changes that support not just the funding of individual services, but also the development of integrated service models. Policies should incentivize collaboration, data sharing, and joint planning among providers to foster a more cohesive health service network.
- **Service Mapping and Gap Analysis**: Regularly update service mappings and gap analyses to identify changing needs and adapt services dynamically. This can help ensure that all populations have adequate coverage and that services evolve as community needs change.

3.1.3 Service Scheduling and Accessibility

The data collected on service delivery scheduling and how to access services in Haldimand is outlined in the tables and summary below.

Provider Name	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Community Addiction and Mental Health Services of Haldimand and Norfolk - AMOT	**8:30am – 8:30pm**	**8:30am – 8:30pm**	**8:30am – 8:30pm**	**8:30am – 8:30pm**	**8:30am – 8:30pm**	**8:30am – 8:30pm**

Brant Haldimand Norfolk RAAM Clinic	**EVERY OTHER MONDAY 9:00am - 3:00pm (Dunnville location)** **9:00am - 3:00pm (Simcoe location)** **VIRTUAL RAAM CLINIC available 9:00am-4:00pm**	**VIRTUAL RAAM CLINIC available 9:00am-3:00pm**	**VIRTUAL RAAM CLINIC available 9:00am-3:00pm**	**EVERY OTHER THURSDAY 9:00am - 3:00pm (Simcoe location)** **VIRTUAL RAAM CLINIC available 9:00am-3:00pm**	**VIRTUAL RAAM CLINIC available 9:00am-3:00pm**	
The AIDS Network - Hamilton & Haldimand	**Missing Data**					

Table 4: Service Delivery Schedules for Haldimand Providers

Provider Name	Direct Access	Referral Access	Self-Referral Accepted
Community Addiction and Mental Health Services of Haldimand and Norfolk - AMOT	**X**	**X**	**X**
Brant Haldimand Norfolk RAAM Clinic		**X**	**X**
The AIDS Network - Hamilton & Haldimand	**X**		

Table 5: Service Access Models for Haldimand Providers

Data Interpretation of Service Delivery Models and Operational Hours in Haldimand:

Community Addiction and Mental Health Services of Haldimand and Norfolk - AMOT: Operates with extended hours from 8:30 AM to 8:30 PM, Monday through Saturday. This schedule enhances accessibility for various populations including encampment residents, individuals with substance use issues, and those with limited access to healthcare, who may face challenges attending appointments during typical work hours.

Brant Haldimand Norfolk RAAM Clinic: Utilizes a hybrid service model with alternating physical presence in Dunnville and Simcoe, and a virtual clinic accessible throughout the week. This flexible approach is crucial for reaching dispersed populations such as youth and individuals with substance use issues, overcoming geographical barriers in rural areas.

The AIDS Network - Hamilton & Haldimand: While specific operational hours in Haldimand are unclear, the flexibility observed in other areas—potentially extending into evenings and weekends—suggests that services could be similarly adaptable in Haldimand, providing broad accessibility to all target populations, including women, gender-diverse groups, and the youth.

Geographic Considerations and Accessibility: Providers focus on servicing rural or remote areas, crucial for reaching dispersed populations in Haldimand. Simcoe serves as an urban hub, likely offering a different range of services or operational hours, enhancing access for a broader demographic.

Service Access Methods: Two providers support both self-referral and direct access methods, which minimizes barriers and promotes engagement based on personal initiative and need, crucial for populations like those in shelters or facing stigma. One provider primarily offers direct access, streamlining the process for users and potentially increasing engagement and continuity of care.

Strategic Implications:

- **AMOT's Extended Hours**: Serve as a best practice model for rural healthcare provision, accommodating the varied schedules of a diverse population.
- **RAAM Clinic's Virtual Services**: This innovative approach addresses geographical challenges effectively and could be expanded to enhance service reach further.
- **Operational Data Gaps for The AIDS Network**: Point to a need for better service documentation and transparency, essential for effective planning and community engagement.

The service delivery landscape in Haldimand reflects thoughtful adaptations to meet the unique needs of its rural populace. Innovations such as virtual care and extended operational hours play pivotal roles in enhancing healthcare access. Moving forward, expanding service model flexibility and improving data documentation will be key to effectively meeting the diverse health needs of this geographically dispersed community.

3.1.4 Funding Sources

Two of the Haldimand providers are funded through diversified funding, one (AMOT) is publicly funded. The funding structure of the healthcare providers indicates variability in resource allocation and potential flexibility in service offerings. Providers with diversified funding sources might have more leeway in expanding or tailoring services based on changing community needs compared to AMOT, which is publicly funded and may face stricter regulatory and budgetary constraints. This could impact the scope and

adaptability of their services. An assessment of funding and mandates would be beneficial to see where there is potential to coordinate and expand services.

3.1.5 Partnerships, Staffing Models, and Evaluation Metrics

The data collected on partnerships, staffing models and evaluation metrics in Haldimand is outlined in the figures, table, and summary below.

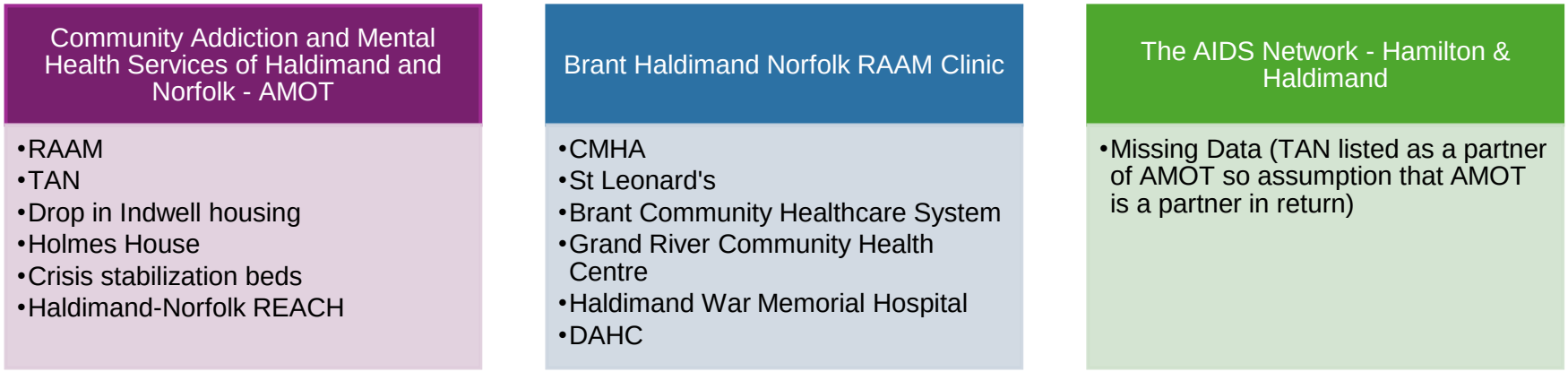


Figure 1: Partnerships in mobile and outreach service delivery in Haldimand. Note: Two of the three providers identified 5 or more partners who support their service delivery via cross-collaboration. One provider (The AIDS Network) was not able to validate or provide their partnership information for this current state analysis.

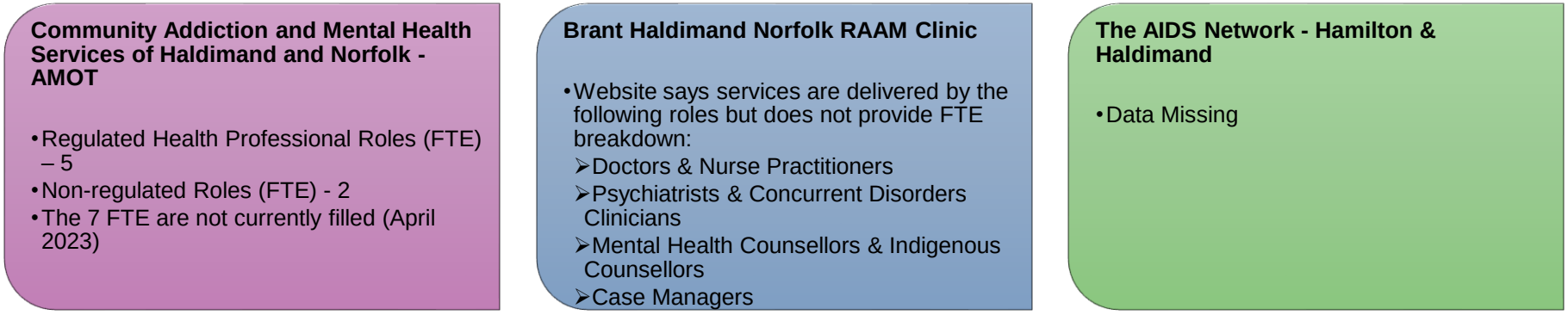


Figure 2: Staffing Models for Haldimand Providers

Provider Name	Feedback from diverse populations	Service utilization and reach metrics	Impact on community health and well-being	Notes
Community Addiction and Mental Health Services of Haldimand and Norfolk - AMOT	X	X	X	
Brant Haldimand Norfolk RAAM Clinic	Missing Data	X	Missing Data	Despite missing data, assumption has been made that some level of service utilization is collected by the provider organization.
The AIDS Network - Hamilton & Haldimand	Missing Data	X	Missing Data	

Table 6: Evaluation Metrics Used by Haldimand Providers

Data Interpretation Summary:

Partnerships - The partnerships listed for Community Addiction and Mental Health Services of Haldimand and Norfolk - AMOT and Brant Haldimand Norfolk RAAM Clinic highlight a strong network of support, integrating various health and social services. Such partnerships are crucial for comprehensive care, indicating a multi-disciplinary approach that spans multiple sectors including housing, crisis support, and hospital care. This broad-based collaboration likely enhances service continuity, referral efficiency, and holistic care delivery. The absence of detailed partnership data for The AIDS Network is a limitation but the likely assumption is that The AIDS Network is working with partners in the area too.

Staffing Models - AMOT's staffing details reveal that not all budgeted positions (FTEs) are filled, which could indicate challenges in recruitment or funding utilization, potentially leading to service delivery gaps or increased workload for existing staff. This could impact the quality of care and the organization's ability to meet community demands. The lack of detailed staffing data for the Brant Haldimand Norfolk RAAM Clinic and The AIDS Network makes it difficult to assess whether these organizations have adequate human resources to cover the health needs of their target populations, which is critical for planning and management.

Success Metrics - Community Addiction and Mental Health Services of Haldimand and Norfolk - AMOT uses a comprehensive set of metrics, which suggests a robust framework for evaluating effectiveness across different dimensions of service delivery. The missing data on certain success metrics for Brant Haldimand Norfolk RAAM Clinic and The AIDS Network may hinder a complete understanding of their impact and could affect their ability to make data-driven improvements.

Strategic Implications

- **Integrated Service Delivery Models:** Given the reliance on partnerships and the broad scope of service delivery models, there is an opportunity to further integrate services across providers. Enhanced evaluation metrics should be built in as part of the design of these integrated service models.
- **Community and Stakeholder Engagement:** Increasing engagement with service users and partners could help in filling the existing data gaps and improving service models based on direct feedback and identified needs.

This analysis underscores the importance of a well-coordinated, adequately staffed, and effectively evaluated healthcare ecosystem, particularly in regions like Haldimand where geographical and resource challenges require innovative and integrated solutions to meet health service demands comprehensively.

3.2 Niagara Northwest's Story

Summary: Service Provision in Niagara Northwest

This report provides a current state analysis of the healthcare and social service landscape in Niagara Northwest as part of a broader initiative by the GHHN to improve service integration for marginalized populations. It is important to note that Niagara Northwest's (NNW) story is told primarily through publicly available data as only one of the providers was able to validate their data in the timeframe of the project.

Key Findings:

Service Gaps: There is a notable deficiency in social support services and comprehensive operational data, with significant disparities in the breadth of services offered across the region. This highlights a need for a more diversified approach to service provision beyond the clinical focus, particularly in direct social care and support services.

Operational Strengths: The region demonstrates strong capabilities in addressing critical health issues such as mental health, substance use, and housing needs. These strengths underscore a focused commitment to tackling some of the most urgent health challenges facing the community.

Staffing and Resource Allocation: The absence of detailed staffing data poses challenges in assessing the adequacy of service delivery and resource allocation. This gap indicates potential issues in ensuring that service provision is aligned with community needs.

Partnerships and Collaboration: While effective collaborations are evident and contribute positively to service delivery, the lack of comprehensive data on partnerships for some areas obscures the full scope of collaborative networks. Enhancing transparency and documentation in this area could further improve service integration and effectiveness.

Strategic Recommendations:

1. **Broaden Service Coordination:** Address significant service gaps by exploring opportunities to coordinate, integrate, or expand services in underrepresented areas such as direct social support services.
2. **Strengthen Staffing Strategies:** Enhance data collection and transparency regarding staffing to ensure that service capacity meets community needs.
3. **Expand Collaborative Networks:** Build on existing collaborations to further connect services and ensure a seamless care pathway.

3.2.1 Who's Doing What?

An analysis of the types of healthcare and social services offered by the providers in NNW is outlined in the tables and summary below.

Provider Name	General Health Services	Contraception Family Planning	Wound Care	First Aid	Chronic Disease Management	Mental Health and Counselling	Substance Use Treatment	Preventive Care and Screenings	Maternal and Reproductive Health	Immunizations	Gender-Affirming Care	STI /HIV testing	STI/HIV treatment	Harm Reduction Supply Distribution	Linking/Bridging to Clinical Services
Niagara Region Outreach Nurses		X	X	X		X		X	X	X		X	X	X	X
Positive Living Niagara		X						X				X	X	X	X
Niagara Region Assertive Street Outreach Team														X	X

Table 7: Healthcare services offered by NNW providers.

Provider Name	Wraparound Mental Health Service Referral	Food Provision and Nutritional Support	Housing and Shelter Assistance	Employment and Education Support	Social Welfare Services	Linking/Bridging to Social Services
Niagara Region Outreach Nurses						X
Positive Living Niagara						X
Niagara Region Assertive Street Outreach Team			X			X

Table 8: Social services offered by NNW providers.

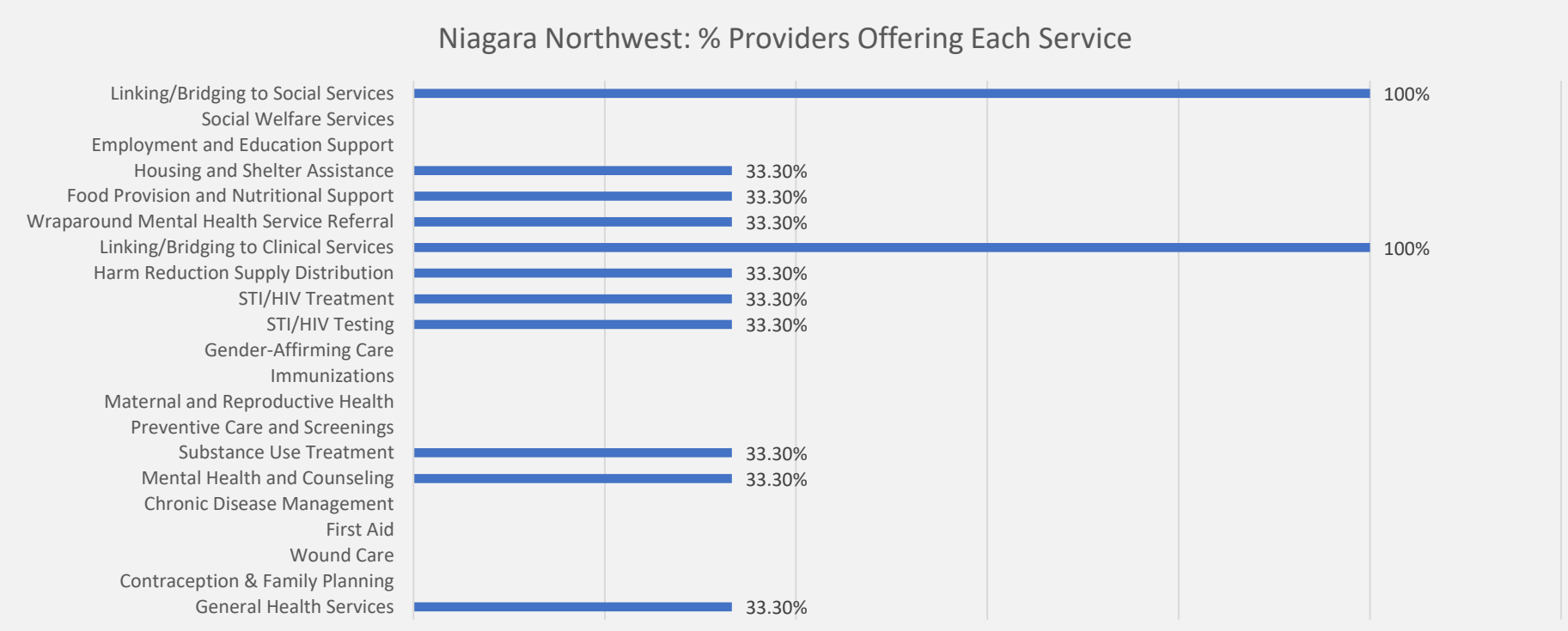


Chart 3: Percent of NNW providers offering each service.

Service Offerings Data Interpretation:

Gap Analysis - The service provision assessment in the Niagara Northwest region, informed by publicly available data, identifies significant gaps, notably in social support services and detailed operational data across providers. Specific gaps include:

- Employment and Education Support
- Food Provision and Nutritional Support
- Social Welfare Services

The identified service gaps suggest that, while clinical services are robust within one primary provider, there is a lack of breadth in service offerings by other providers, particularly in direct social care and detailed service accessibility.

Current Strengths - The region benefits from specialized providers who deliver targeted services, addressing critical health and social needs:

- Broad Medical Services: Offered primarily by the Niagara Region Outreach Nurses, addressing a wide spectrum of medical needs.
- Focused Mental Health and Substance Use Services: Provided by Positive Living Niagara, including harm reduction and STI/HIV testing and treatment.
- Housing and Shelter Assistance: Specifically offered by the Niagara Region Assertive Street Outreach Team, addressing critical shelter needs.

Strategic Implications and Additional Considerations - The data analysis underscores the need for:

- A more integrated care model that bridges the gap between extensive clinical services and the sparse social support network.
- Expansion and diversification of social support services to foster a more comprehensive care system.
- Improved data collection and validation to ensure a thorough understanding of service accessibility and to facilitate strategic planning.

In summary, while Niagara Northwest has a strong primary healthcare provider in the Niagara Region Outreach Nurses, the overall healthcare and social service system requires significant enhancement. Strengthening the integration of services, addressing social care gaps, and ensuring thorough data collection are key strategic needs. These improvements are essential to develop holistic and sustainable health and social care systems for the diverse and underserved populations in Niagara Northwest.

3.2.2 Who's being served?

An analysis of the priority populations eligible to access the mobile and outreach-based services in NNW is outlined in the table and summary below.

Provider Name	Encampment Residents	People who use substances or experiencing addiction	Women and Gender-Diverse Populations	Individuals with Limited Access to Healthcare	Youth and Young Adults (up to 24 years old)	Men in the shelter system
Niagara Region Outreach Nurses	X	X	X	X	X	
Positive Living Niagara		X		X		
Niagara Region Assertive Street Outreach Team	X	X		X		

Table 9: Priority Populations Served in Niagara Northwest. Note: Positive Living Niagara noted that their services are anyone living in or visiting Niagara Region and that the Streetworks Program is for people who inject drugs. Niagara Outreach Nurses noted they also serve single parent/low income families, refugees, new immigrants, Indigenous populations. If any of the providers offer services tailored specifically for men involved in the shelter system, this information was not publicly available at the time of the analysis.

Service Users	Percent of Providers
Encampment Residents	66.7%
People who use substances or experiencing addiction	66.7%
Women and Gender-Diverse Populations	33.3%
Individuals with Limited Access to Healthcare	100%
Youth and Young Adults (up to 24 years old)	0
Men in the shelter system	0

Chart 4: Percent of NNW providers who serve each priority population group.

Data Interpretation of Populations Served:

In Niagara Northwest, healthcare providers cater to a broad range of populations, reflecting the region's diverse health and social needs. Service delivery is characterized by both a comprehensive and specialized focus.

In Niagara Northwest, the healthcare providers are tailored to address specific community needs, ensuring targeted support for various vulnerable groups. Niagara Region Outreach Nurses provide extensive healthcare services to a range of populations, including encampment residents, individuals with substance use issues, women and gender-diverse populations, and those with limited access to healthcare. Their comprehensive approach covers a wide array of medical and social needs, reflecting their role as a pivotal healthcare provider in the region. Positive Living Niagara focuses on serving individuals who use substances or are experiencing addiction, providing essential services geared towards this demographic. Niagara Region Assertive Street Outreach Team targets their services primarily towards encampment residents and individuals with limited access to healthcare, emphasizing harm reduction and linking these populations to necessary clinical services.

Cross-Tabulation Summary of Healthcare and Social Services in Niagara Northwest:

Niagara Region Outreach Nurses	Offers a comprehensive range of healthcare services, notably including general health and gender-affirming care, serving encampment residents, people using substances or experiencing addiction, women and gender-diverse populations, and those with limited access to healthcare.
Positive Living Niagara	Provides specialized care primarily for individuals experiencing substance use issues, focusing on targeted interventions.
Niagara Region Assertive Street Outreach Team	Concentrates on harm reduction and linking to clinical services, with a strong emphasis on housing and shelter assistance, targeting encampment residents and individuals with limited access to healthcare.
Key Observations: • Niagara Region Outreach Nurses are crucial for their extensive service provision, ensuring that a wide array of medical needs are met within the community. • Positive Living Niagara targets specific health challenges related to substance use, providing essential care to this particular demographic. • Niagara Region Assertive Street Outreach Team plays a critical role in emergency and crisis intervention, focusing on immediate needs and connecting individuals to ongoing healthcare resources.	

Strategic Recommendations:

- **Broaden Service Offerings:** Encourage providers to offer additional health services, especially those related to social care, to create a more comprehensive service network. Encourage providers to extend their services to include neglected demographics, particularly youth, which currently lacks targeted services.
- **Collaborative Service Delivery:** Strengthen partnerships between organizations to ensure a cohesive approach to healthcare and social service delivery, filling any critical gaps.
- **Enhanced Accessibility and Data Collection:** Collect detailed data on service access times and operational models to provide a clearer picture of service delivery and accessibility.

3.2.3 Service Scheduling and Accessibility

The data collected on service delivery scheduling and how to access services in NNW is outlined in the tables and summary below.

Provider Name	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Niagara Region Outreach Nurses	Varies across the week depending on client and community agency need.						
Positive Living Niagara	StreetWorks program 9am-5pm Mobile van 6pm-10:30pm	StreetWorks program 9am-5pm Mobile van 6pm-10:30pm	StreetWorks program 9am-5pm Mobile van 6pm-10:30pm	StreetWorks program 9am-5pm Mobile van 6pm-10:30pm	StreetWorks program 9am-5pm Mobile van 6pm-10:30pm		
Niagara Region Assertive Street Outreach Team	7am-11pm	7am-11pm	7am-11pm	7am-11pm	7am-11pm	9am - 11pm	9am - 11pm

Table 10: Service Delivery Schedules for Niagara Northwest Providers.

Provider Name	Direct Access	Referral Access	Self-Referral Accepted
Niagara Region Outreach Nurses	X		
Positive Living Niagara	X		
Niagara Region Assertive Street Outreach Team	X		

Table 11: Service Access Models for Niagara Northwest Providers.

Niagara Northwest Service Delivery Models and Operational Hours:

Niagara Region Outreach Nurses: Service hours are stated to vary across the week with some occasional evenings and weekends. While flexibility in service delivery can be helpful, it can also lead to confusion on the part of service users if a set schedule is not established.

Positive Living Niagara: Offers extended service hours through the StreetWorks program, with mobile services available until 10:30 PM on weekdays, catering to individuals who may require services beyond standard business hours.

Niagara Region Assertive Street Outreach Team: Provides the most comprehensive access with operational hours from 7 AM to 11 PM, including weekends, ensuring vital health services are available for emergencies and urgent care needs across varied schedules.

Geographic Considerations and Accessibility: Services in Niagara Northwest are presumed to be offered primarily in Urban and High-Density Areas (Downtown Core), with coverage extending to Suburban and Peri-Urban Areas and some presence in rural or remote areas, reflecting a commitment to serving diverse geographic populations.

Service Access Methods: All three providers in Niagara Northwest offer direct access to eligible populations, simplifying the process for those seeking assistance and minimizing barriers to entry.

Insights from Service Delivery Models:

Extended Hours and Accessibility: Positive Living Niagara's extended hours and weekend services by the Niagara Region Assertive Street Outreach Team demonstrate an understanding of the community's needs, providing valuable access points outside of typical service hours.

Service Patterns Uncertainty: Without specific operational times, the service patterns of the Niagara Region Outreach Nurses remain unclear, potentially affecting the perception of their accessibility and the actual reach of services provided.

Strategic Implications:

- **Service Flexibility and Integration**: Varied operational hours across providers underscore the necessity for flexible service delivery models that cater to the unique lifestyles within the community.
- **Enhanced Data Collection**: Improved transparency and availability of detailed operational data are crucial for understanding service efficacy and for informed strategic planning.

Niagara Northwest's healthcare providers adapt to the community's needs with services that range from weekday evenings to weekend availability, ensuring substantial coverage. Yet, the lack of detailed operational data and gaps in continuous care point

towards areas for strategic improvement. Enhancing flexibility, data transparency, and integration of services will be instrumental in advancing health outcomes and resource efficiency within the region.

3.2.4 Funding Sources

Public and Diversified Funding: No definitive insights about funding can be assigned to NNW due to a lack of validated funding source data. Niagara Region Outreach Nurses confirmed they receive public funding. The remaining two providers in Niagara Northwest are likely supported by public funding, possibly supplemented by diversified funding models. This implies a reliance on governmental and potentially varied additional sources, which may influence the scope and sustainability of services offered.

3.2.5 Partnerships, Staffing Models, and Evaluation Metrics

The data collected on partnerships, staffing models, and evaluation metrics in NNW is outlined in the figure, table, and summary below.

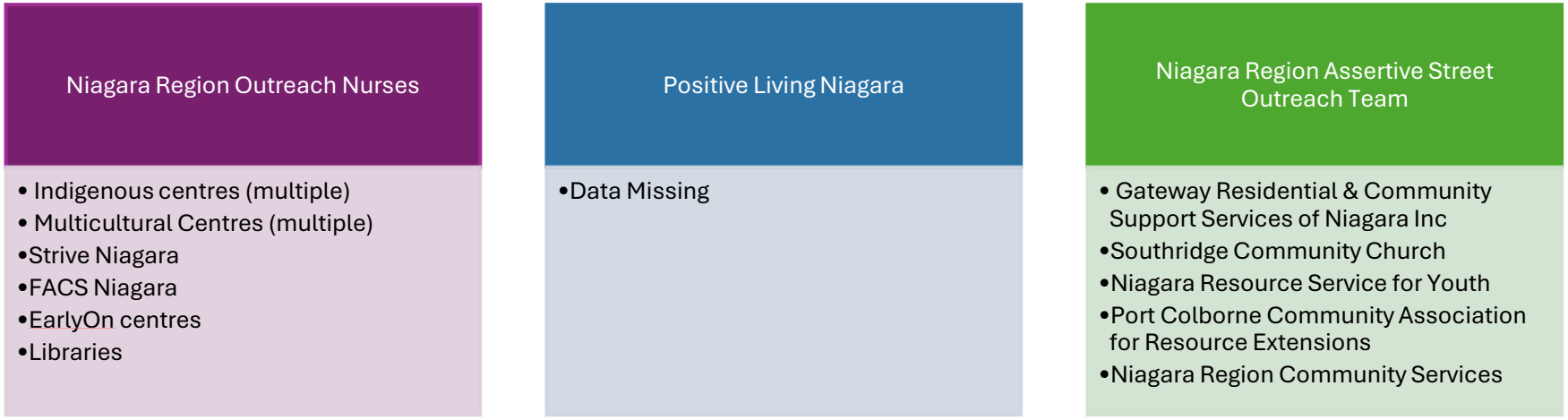


Figure 3: Partnerships in mobile and outreach service delivery in Niagara Northwest.

Provider Name	Feedback from diverse populations	Service utilization and reach metrics	Impact on community health and well-being	Notes
Niagara Region Outreach Nurses		X	X	
Positive Living Niagara		X		Despite missing data, assumption has been made that some level of service utilization is collected by the provider organization.
Niagara Region Assertive Street Outreach Team		X		

Table 12: Evaluation Metrics Used by NNW Providers.

Data Interpretation Summary

Partnerships - The Niagara Region Assertive Street Outreach Team maintains a robust cross-collaborative approach, partnering with various local organizations, including Gateway Residential & Community Support Services of Niagara Inc, Southridge Community Church, and Niagara Resource Service for Youth, among others, to enhance service delivery through integrated community support. In contrast, the Niagara Region Outreach Nurses collaborate extensively with diverse community centres and services such as multiple Indigenous and Multicultural Centres, Strive Niagara, FACS Niagara, EarlyOn centres, and libraries, indicating a broad scope of community integration. Data on partnerships for Positive Living Niagara is currently missing, highlighting a gap in available information on their collaborative efforts.

Staffing Models - The absence of detailed staffing data, including Full-Time Equivalents (FTE) and other staffing breakdowns for all providers, restricts a thorough analysis of service capacity and workforce adequacy. This gap hinders the assessment of whether current staffing levels adequately meet community needs or if there are significant service delivery constraints due to workforce limitations.

Success Metrics - While specific metrics on feedback from diverse populations and the direct impact on community health and well-being are missing from most of the providers (with the exception of Niagara Region Outreach Nurses), there is an assumption that some level of service utilization data is being collected by all the providers. This suggests an ongoing effort to monitor service reach

and effectiveness, although the lack of comprehensive data prevents a full understanding of the outcomes and efficiency of the services provided.

Strategic Implications and Recommendations

Enhanced Data Transparency and Collection - A critical need exists for improved transparency and systematic data collection across all areas of service provision in NNW. There is a specific requirement for detailed information on partnerships and staffing. This will enable better strategic planning, resource allocation, and community engagement, ensuring that services are aligned with community needs.

Strengthening Partnerships - For providers like Positive Living Niagara, where partnership data is missing, there is an opportunity to develop and disclose collaborative relationships with community organizations. Emulating the robust partnership models of the Niagara Region Assertive Street Outreach Team can broaden service reach and enhance community impact, ensuring a comprehensive support network is available.

Workforce Development - Addressing the gaps in staffing data and enhancing workforce capabilities should be prioritized. Developing a clear understanding of staffing needs based on service utilization metrics and aligning them with community demands will likely improve service delivery effectiveness. Initiatives could include targeted recruitment, specialized training, and expanding staff numbers where needed.

Robust Impact Assessment - Implementing comprehensive methods for tracking the effectiveness of services is crucial. This includes establishing feedback mechanisms from diverse populations and conducting detailed assessments of the impact on community health. Such measures will provide vital insights that can drive service improvements and underscore the value of the services provided.

Optimize Resource Utilization - With the Niagara Region Outreach Nurses and the Assertive Street Outreach Team showcasing broad and effective partnerships, it is essential to ensure that these collaborations are leveraged to optimize resource utilization. This could involve coordinated service schedules, shared training, and joint funding initiatives to enhance service delivery and avoid duplication.

In Niagara Northwest, while there is a structured approach to healthcare and social service delivery supported by public and possibly diversified funding, significant gaps in data on staffing and success metrics pose challenges to fully understanding and optimizing service provision. Addressing these gaps through strategic data enhancement, collaborative efforts, and workforce development will be crucial in building a more responsive and effective service delivery model for the community.

3.3 Hamilton's Story

Summary: Mobile and Outreach Service Provision in Hamilton

This report provides a current state analysis of the healthcare and social service landscape in Haldimand as part of a broader initiative by the GHHN to improve service integration for marginalized populations.

Key Findings:

Comprehensive and Diverse Service Delivery: Hamilton's service providers offer a wide array of healthcare and social care services tailored to meet the needs of diverse populations, including those facing homelessness, substance use, and complex health conditions. This comprehensive approach highlights a strong network of support that addresses both immediate and long-term health needs across the community.

Strategic Gaps and Opportunities: Despite the extensive range of services, there are noticeable gaps in primary care and specialized services such as gender-affirming care and specific preventive screenings. These gaps present strategic opportunities for developing localized solutions that could significantly enhance the healthcare landscape.

Service Accessibility and Scheduling: Hamilton's healthcare providers demonstrate a commitment to accessibility through extended service hours, including evenings and weekends, with some providers like the Hamilton Midwives Outreach Team offering 24/7 availability. Notably, there is a redundancy in service scheduling among providers, which presents an opportunity to reallocate resources to broaden service reach, ensuring that care is available across a wider array of settings and times.

Staffing and Partnership Models: Hamilton's service providers benefit from robust and strategic partnerships that enhance their service offerings. These collaborations, which often include cross-sector linkages, contribute to comprehensive care delivery. However, staffing challenges, particularly in filling specialized roles, impact service continuity and the scope of available services, underscoring the need for innovative recruitment and retention strategies.

Data Validation Note: It is important to note that data for three of the nineteen providers analyzed—The AIDS Network of Hamilton and Haldimand, The Hamilton Regional Indian Center, and De dwa da dehs nye>s Aboriginal Health Centre—relies solely on publicly available information due to validation constraints.

Strategic Recommendations:

1. **Enhance Service Integration:** The diversity and breadth of services highlight the need for more cohesive health and social service models to effectively address the broad determinants of health.

2. **Optimize Collaborative Networks:** Improving collaboration and coordination between service providers is crucial to optimize resource utilization and ensure comprehensive care delivery. This includes developing community-based initiatives that could fill service voids, particularly in general health and chronic disease management.
3. **Advance Policy Advocacy and Service Mapping:** Advocating for policy changes that support integrated service models and conducting regular service mappings and gap analyses are essential for adapting services to evolving community needs.

Conclusion:

Hamilton's network of healthcare providers showcases a landscape of diverse and comprehensive service delivery against a backdrop of urban complexity and notable health disparities. To effectively tackle these challenges, it is crucial to enhance service integration and optimize collaborative networks, ensuring that resources are utilized efficiently, and care reaches key populations in need. Moreover, advancing policy advocacy and service mapping will support these efforts by fostering adaptable, integrated service models that respond to evolving needs.

3.3.1 Who's Doing What?

An analysis of the types of healthcare and social services offered by the providers in Hamilton is outlined in the tables and summary below.

Provider Name	General Health Services	Contraception Family Planning	Wound Care	First Aid	Chronic Disease Management	Mental Health and Counselling	Substance Use Treatment	Preventive Care and Screenings	Maternal and Reproductive Health	Immunizations	Gender-Affirming Care	STI /HIV testing	STI/HIV treatment	Harm Reduction Supply Distribution	Linking/Bridging to Clinical Services
CMHA Street Team, Peer Support Services Outreach & MH Navigator, RIST; Canadian Mental Health Association, Hamilton Branch	X	X	X	X	X	X	X	X				X	X	X	X

Provider Name	General Health Services	Contraception Family Planning	Wound Care	First Aid	Chronic Disease Management	Mental Health and Counselling	Substance Use Treatment	Preventive Care and Screenings	Maternal and Reproductive Health	Immunizations	Gender-Affirming Care	STI /HIV testing	STI/HIV treatment	Harm Reduction Supply Distribution	Linking/Bridging to Clinical Services
St Matthew's/City of Hamilton - Housing Focused Street Outreach															X
De dwada dehs nye>s Aboriginal Health Centre Mobile Medical Clinic	X	X	X	X				X		X				X	X
Good Shepherd Health on Wheels Mobile Health Clinic	X	X	X	X	X	X		X						X	X
Hamilton Midwives Outreach Team		X							X			X	X	X	X
HAMSMaRT / Keeping Six	X	X	X	X		X	X					X	X	X	X
Wayside House of Hamilton - HepC Outreach Team							X			X					X

Provider Name	General Health Services	Contraception Family Planning	Wound Care	First Aid	Chronic Disease Management	Mental Health and Counselling	Substance Use Treatment	Preventive Care and Screenings	Maternal and Reproductive Health	Immunizations	Gender-Affirming Care	STI /HIV testing	STI/HIV treatment	Harm Reduction Supply Distribution	Linking/Bridging to Clinical Services
Hamilton Health Sciences - Hospital 2 Home					X	X								X	X
Hamilton Regional Indian Center - Mobile Street Outreach															X
Hamilton Police Service - Social Navigator Program(SNP) & Rapid Intervention and Support Team (RIST)			X	X										X	X
The Hub - Street Outreach Clinics	X					X	X	X		X		X	X	X	X
City of Hamilton Public Health Services - Harm Reduction Program		X	X	X		X	X			X		X	X	X	X

Provider Name	General Health Services	Contraception Family Planning	Wound Care	First Aid	Chronic Disease Management	Mental Health and Counselling	Substance Use Treatment	Preventive Care and Screenings	Maternal and Reproductive Health	Immunizations	Gender-Affirming Care	STI /HIV testing	STI/HIV treatment	Harm Reduction Supply Distribution	Linking/Bridging to Clinical Services
City of Hamilton Public Health Services - Mental Health and Street Outreach Program				X		X	X							X	X
Good Shepherd RAAM - Mobile and Community-Based Program							X							X	X
St. Joseph's Healthcare Hamilton - Hospital 2 Home					X	X								X	X
Wesley Provincial Youth Outreach Workers Hamilton/Brantford															X
YWCA Emergency Reproduction Care - Mobile		X							X			X	X	X	X

Provider Name	General Health Services	Contraception Family Planning	Wound Care	First Aid	Chronic Disease Management	Mental Health and Counselling	Substance Use Treatment	Preventive Care and Screenings	Maternal and Reproductive Health	Immunizations	Gender-Affirming Care	STI /HIV testing	STI/HIV treatment	Harm Reduction Supply Distribution	Linking/Bridging to Clinical Services
Shelter Health Network	X	X	X	X	X	X	X	X	X	X		X	X	X	X
The AIDS Network - Hamilton & Haldimand*		X									X	X	X	X	X

Table 13: Healthcare services offered by providers in Hamilton.

Additional healthcare services offered by providers that were not measured in the data collection tool:

- CMHA Street Team offers contraception but not family planning; also offers advanced wound care, phlebotomy.
- Shelter Health Network offers Specialized HepC through the HepC team.
- Hamilton Police Social Navigator Program offers hygiene products, clothes/boots, medication assistance, and safety planning.
- Hospital to Home for HHS and St. Joesph's Healthcare work directly with patients to develop coordinated care plans.
- Wayside House Hep C team offers Hepatitis C testing, treatment, counselling and case management.
- Hamilton Midwives offer prenatal, antenatal, and post partum care.

Provider Name	Wraparound Mental Health Service Referral	Food Provision and Nutritional Support	Housing and Shelter Assistance	Employment and Education Support	Social Welfare Services	Linking/Bridging to Social Services
CMHA Street Team, Peer Support Services Outreach & MH Navigator, RIST; Canadian Mental Health Association, Hamilton Branch	X	X				X
St Matthew's/City of Hamilton – Housing Focused Street Outreach			X		X	X
De dwada dehs nye>s Aboriginal Health Centre Mobile Medical Clinic		X				X
Good Shepherd Health on Wheels Mobile Health Clinic	X	X				X
Hamilton Midwives Outreach Team	X					X
HAMSMaRT / Keeping Six		X				X
Wayside House of Hamilton – HepC Outreach Team						X
Hamilton Health Sciences – Hospital 2 Home	X				X	X

Provider Name	Wraparound Mental Health Service Referral	Food Provision and Nutritional Support	Housing and Shelter Assistance	Employment and Education Support	Social Welfare Services	Linking/Bridging to Social Services
Hamilton Regional Indian Center – Mobile Street Outreach		X				X
Hamilton Police Service – Social Navigator Program(SNP) & Rapid Intervention and Support Team (RIST)	X	X	X		X	X
The Hub – Street Outreach Clinics						X
City of Hamilton Public Health Services – Harm Reduction Program						X
City of Hamilton Public Health Services – Mental Health and Street Outreach Program	X	X	X	X	X	X
Good Shepherd RAAM – Mobile and Community-Based Program	X					X
St. Joseph's Healthcare Hamilton – Hospital 2 Home	X				X	X
Wesley Provincial Youth Outreach Workers Hamilton/Brantford						X

Provider Name	Wraparound Mental Health Service Referral	Food Provision and Nutritional Support	Housing and Shelter Assistance	Employment and Education Support	Social Welfare Services	Linking/Bridging to Social Services
YWCA Emergency Reproduction Care – Mobile	X	X	X	X		X
Shelter Health Network	X					X
The AIDS Network – Hamilton & Haldimand*						X

Table 14: Social services offered by providers in Hamilton.

Additional social care services offered by providers not measured in the data collection tool:

- YWCA Emergency Reproductive Care clarified that wraparound mental health supports, employment support and food provision are offered within YWCA programs on transitional living, immigration & settlement and drop in shelter.
- The Hub offers basic needs drop off, such a tents and snacks.
- Wayside House Hep C Team offers peer-led support group for people HepC or at-risk for HepC.
- HAMSMaRT/Keeping Six offers arts and creative workshops.

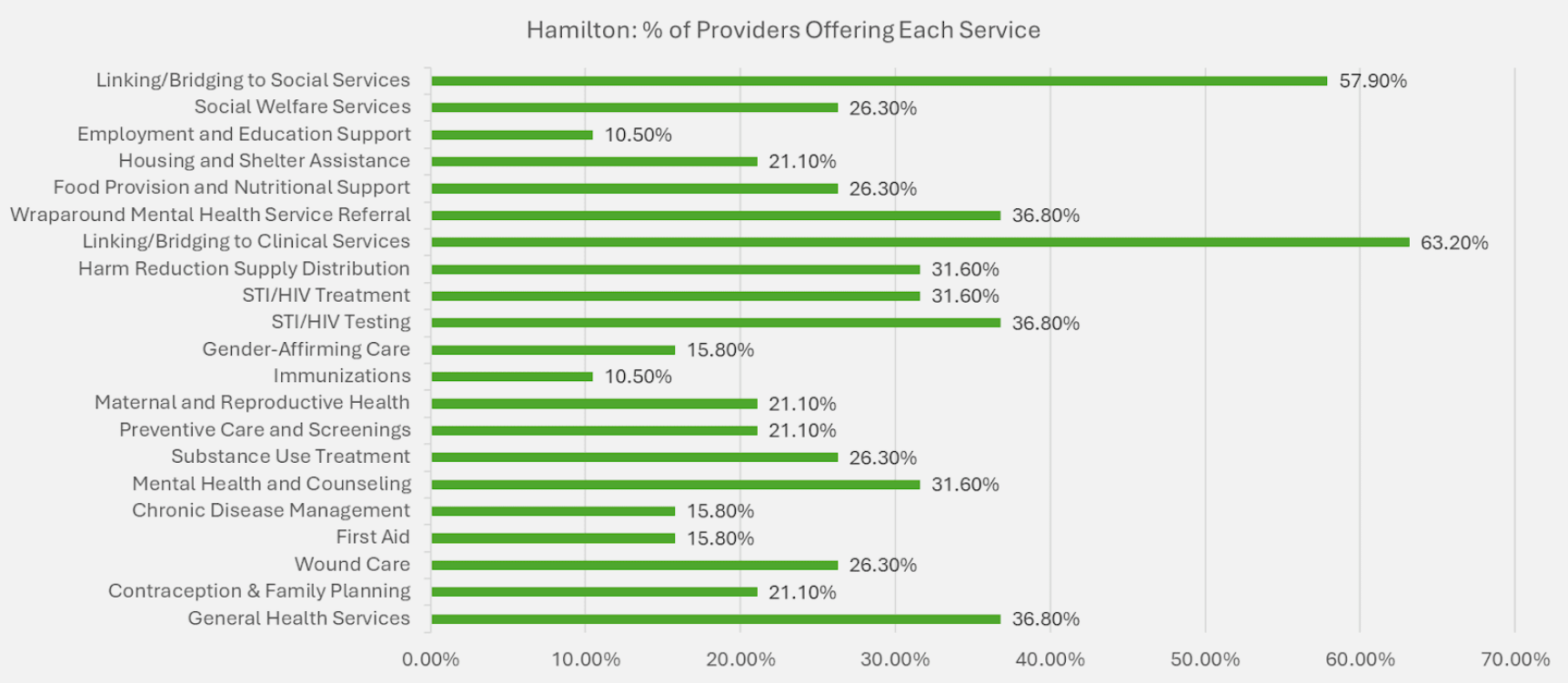


Chart 5: Percent of Hamilton providers offering each service.

Service Offerings Data Interpretation

Hamilton's healthcare landscape features a robust array of service providers delivering comprehensive and specialized services. These include general health, chronic disease management, mental health counseling, substance use treatment, and focused areas such as maternal health and infectious disease management.

Gap Analysis

Despite the comprehensive services offered, there are noticeable gaps:

- **Primary Care and Specialized Services:** There is a lack of uniform provision of gender-affirming care and certain preventive screenings, suggesting a potential reliance on external facilities or a need for local development.

- **Mental Health and Substance Use:** The substantial focus on mental health and substance use treatment across several providers highlights these as critical community issues, requiring targeted and sustained intervention strategies.

Current Strengths

- **Broad Range of Healthcare Services:** Providers like the CMHA Street Team and Good Shepherd Health on Wheels offer extensive healthcare services, critical in providing first-line defense and ongoing support for a wide array of health concerns.
- **Specialized Services:** Entities like Hamilton Midwives and Wayside House provide specialized care in reproductive health and Hepatitis C treatment, respectively.
- **STI/HIV Management and Harm Reduction:** Many providers, such as The AIDS Network and City of Hamilton Public Health Services, emphasize STI/HIV testing and harm reduction.
- **Linking/Bridging to Clinical and Social Services:** Nearly all providers facilitate linkage to additional clinical or social resources, demonstrating an integrative approach that helps individuals navigate to necessary specialized medical care and social support services.

Strategic Implications and Additional Considerations

Need for Integrated Service Models: There is a critical need for more integrated health and social service models to provide comprehensive care effectively and address the broader determinants of health.

Community-Based Health Initiatives: The gaps in direct service provision present opportunities to develop community-based health initiatives that could provide missing services, particularly in general health and chronic disease management.

Enhanced Collaboration: Improved collaboration and coordination between different service providers and stakeholders could enhance resource utilization and service delivery, filling the identified service gaps.

3.3.2 Who's being served?

An analysis of the priority populations eligible to access the mobile and outreach-based services in Hamilton is outlined in the table and summary below.

Provider Name	Encampment Residents	People who use substances or experiencing addiction	Women and Gender-Diverse Populations	Individuals with Limited Access to Healthcare	Youth and Young Adults (up to 24 years old)	Men in the shelter system
CMHA Street Team, Peer Support Services Outreach & MH Navigator, RIST; Canadian Mental Health Association, Hamilton Branch	X	X	X	X	X	X
St Matthew's/City of Hamilton - Housing Focused Street Outreach	X					
De dwada dehs nye>s Aboriginal Health Centre Mobile Medical Clinic	X	X	X	X	X	X
Good Shepherd Health on Wheels Mobile Health Clinic	X	X	X	X	X	X
Hamilton Midwives Outreach Team	X	X	X	X	X	
HAMSMaRT / Keeping Six	X	X	X	X		

Provider Name	Encampment Residents	People who use substances or experiencing addiction	Women and Gender-Diverse Populations	Individuals with Limited Access to Healthcare	Youth and Young Adults (up to 24 years old)	Men in the shelter system
Wayside House of Hamilton - HepC Outreach Team	X	X	X	X	X	X
Hamilton Health Sciences - Hospital 2 Home						
Hamilton Regional Indian Center - Mobile Street Outreach	X		X	X		X
Hamilton Police Service - Social Navigator Program(SNP) & Rapid Intervention and Support Team (RIST)	X	X	X	X	X	X
The Hub - Street Outreach Clinics	X	X	X	X	X	X
City of Hamilton Public Health Services - Harm Reduction Program	X	X	X	X	X	X

Provider Name	Encampment Residents	People who use substances or experiencing addiction	Women and Gender-Diverse Populations	Individuals with Limited Access to Healthcare	Youth and Young Adults (up to 24 years old)	Men in the shelter system
City of Hamilton Public Health Services - Mental Health and Street Outreach Program	X	X		X		
Good Shepherd RAAM - Mobile and Community-Based Program	X	X		X		
St. Joseph's Healthcare Hamilton - Hospital 2 Home		X				
Wesley Provincial Youth Outreach Workers Hamilton/Brantford					X	
YWCA Emergency Reproduction Care - Mobile	X	X	X	X	X	
Shelter Health Network	X	X	X	X	X	X
The AIDS Network - Hamilton & Haldimand*	X	X	X	X	X	X

Table 15: Priority Populations Served in Hamilton.

Additional populations served by providers that were not measured in the data collection tool:

- CMHA Street Team: People with serious mental illness.
- De dwada dehs nye>s Aboriginal Health Centre Mobile Medical Clinic: Indigenous community members in Hamilton who are precariously housed or at risk of homelessness.
- Good Shepherd Health on Wheels: Newcomers.
- HAMSMaRT/Keeping Six: Family/friends of people with addiction or use drugs.
- Wayside House HepC Outreach: Anyone who is living with or at risk of acquiring Hepatitis C qualifies for services. People involved with the correctional system. People who are homeless or under-housed. Aboriginal Peoples. Street-involved youth. People with tattoos and/or body piercings.
- Hamilton Health Sciences Hospital 2 Home: Focused on people with 5 or more chronic conditions and 4 or more visits to hospitals over 12 months. Patients who are impacted by chronic conditions and face social or economic barriers to achieving good health - Barriers experienced by this population include poor health literacy, mental-health challenges, frailty, lack of social supports, isolation due to impaired physical/cognitive function, lack of food security, and lack of other basic needs.
- Hamilton Regional Indian Center: Indigenous and non-Indigenous community members; can be housed.
- Hamilton Police Services SNP and RIST: Those with frequent interactions with police and ambulance due to underlying issues such as mental health, addiction, lack of housing, lack of income etc; Homeless, at-risk of becoming homeless and those housed who meet above criteria; Often too complex to access other tradition services or restricted from all services due to behaviour.
- The Hub: work with youth ages 17-27 involved in the high-risk youth category ie., those involved in the intervention and suppression stages of gang activity. This is also inclusive of those in custody, we support both while they are inside, release planning and post release.
- City of Hamilton Public Health Services Harm Reduction Program: individuals living with HIV/AIDs, gay or bisexual men who have sex with men, Indigenous Peoples, incarcerated people and individuals who engage in sex work.
- City of Hamilton Public Health Services Mental Health & Street Outreach Program: People living with mental illness.
- Good Shepherd RAAM clinic: Transient or vulnerable populations including those experiencing homelessness.
- St. Joesph's Healthcare Hospital 2 Home: Clients with complex needs -multiple chronic conditions, medical instability, mental health and addictions issues and impaired cognitive function. Additionally, many individuals also have social issues which drive high acute care use including financial difficulties, inadequate or poor transportation, low literacy or health literacy, homelessness or substandard housing.
- Wesley Youth Outreach: Youth 12-21 years – outreach workers may use their discretion to serve high risk youth as young as 6 and up to the age of 25.

- Shelter Health Network: serves variety of populations in different clinics: Women/Gender Diverse: Willow's Place clinic Womankind clinic YWCA clinic, Women's Clinic, Good Shepherd, Indwell clinic, Hamilton Clinic; Youth/Young Adults: Youth Wellness clinic, Notre Dame clinic; Men in the shelter system: Wayside clinic (Men's Housing), Men's Addiction Service clinic, Mission Services clinic, Salvation Army clinic, Good Shepherd Men's center, Indwell clinic, Hamilton Clinic.

Service Users	Percent of Providers
Encampment Residents	52.6%
People who use substances or experiencing addiction	52.6%
Women and Gender-Diverse Populations	47.4%
Individuals with Limited Access to Healthcare	57.9%
Youth and Young Adults (up to 24 years old)	31.6%
Men in the shelter system	26.3%

Chart 6: Percent of Hamilton providers who serve each priority population group.

Data Interpretation of Populations Served

In Hamilton, the diverse array of target populations served by healthcare providers reflects a deep commitment to addressing specific and often overlapping health and social needs. This analysis reveals both broad and focused efforts to support varied community members, highlighting the extensive outreach and comprehensive service models employed across the region.

Gaps and Overlaps:

- While there is robust coverage across various populations, there are gaps in services for certain demographics within the provider data, particularly in direct healthcare provisions for specific subgroups like women and gender-diverse individuals, where more specialized care may be necessary.
- Notably, there is considerable overlap in services for people using substances and those with limited healthcare access, indicating a high level of need in these areas. This overlap, far from being merely redundant, presents an opportunity to streamline and coordinate services to maximize their reach and effectiveness. It highlights the potential for enhanced collaboration among providers to ensure that resources are efficiently utilized, and that all key populations receive comprehensive, continuous support tailored to their specific circumstances.

- The extensive service overlap also suggests that providers could benefit from shared strategies and communication to avoid service duplication, thus freeing up resources that could be extended to underserved groups or used to deepen service offerings in critical areas of need.

Cross-Tabulation Summary of Healthcare and Social Services in Hamilton:

Broad and Inclusive Service Delivery	Most providers, such as Good Shepherd Health on Wheels, Hamilton Police Service's Social Navigator Program, and City of Hamilton Public Health Services, offer services to a wide range of populations including encampment residents, individuals using substances, and those with limited access to healthcare. This widespread approach demonstrates a significant effort to reach diverse groups, particularly those who are often marginalized or face barriers in accessing conventional healthcare services.
Targeted Healthcare Services	Specialized services are also evident, with providers like the Shelter Health Network and Hamilton Health Sciences' Hospital 2 Home focusing on subgroups such as individuals with multiple chronic conditions or those who frequently utilize hospital services. These targeted initiatives are critical in managing complex health needs and reducing systemic healthcare burdens. De dwada dehs nye>s Aboriginal Health Centre and Hamilton Regional Indian Center specifically cater to Indigenous communities, providing culturally sensitive care that addresses both health and social determinants impacting these populations.
Integration of Social Determinants of Health	Several providers integrate services that address social determinants of health, such as the Hamilton Police Service programs and St. Joseph's Healthcare Hospital 2 Home, which support individuals facing complex social challenges like homelessness, mental health issues, and economic barriers. These programs emphasize a holistic approach to health that extends beyond medical treatment to include social support and crisis intervention.
Services for High-Risk and Specialized Groups	Providers like The Hub target specific demographics such as high-risk youth involved in gang activities, offering both intervention and support services that are tailored to the unique challenges faced by this group. Similarly, Wesley Youth Outreach provides services to a broad age range of youth, recognizing the diverse needs that can arise during different stages of young adulthood.
Key Observations: • Comprehensive Care: Providers like The AIDS Network and Shelter Health Network are notable for their wide-ranging services that address both healthcare and social needs for multiple key populations. • Tailored Support: Additional populations listed in the notes reveal that many providers target their services to niche populations, ensuring that various segments of the community receive tailored support.	

Strategic Recommendations

This analysis underscores the need for enhanced service coordination and integration across providers in Hamilton to effectively address the healthcare gaps without necessitating unrealistic expansions of individual services. Recommendations include:

- **Enhanced Coordination**: Develop a coordinated service model that leverages the strengths of existing providers, involving clear protocols for referrals and shared care plans.
- **Collaborative Networks**: Strengthen networks among providers to facilitate a comprehensive system of wrap-around services, enhancing collaboration through regular communication forums and shared training sessions.
- **Policy Advocacy**: Advocate for policy changes that support the development of integrated service models and foster a cohesive health service network.
- **Service Mapping and Gap Analysis**: Regularly update service mappings and gap analyses to dynamically adapt services as community needs evolve.

This comprehensive approach to service provision in Hamilton highlights a strong network of support for a wide array of community members. However, the focus on such a broad spectrum also underscores the necessity for continuous assessment and adaptation of services to ensure that all groups, especially those with highly specialized needs, receive appropriate and effective support. The strategic implications suggest a continued need for integrated service models and enhanced collaborations to fill any existing gaps and to build on the strengths of current healthcare and social service frameworks in Hamilton.

3.3.3 Service Scheduling and Accessibility

The data collected on service delivery scheduling and how to access services in Hamilton is outlined in the tables and summary below.

Provider Name	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
CMHA Street Team, Peer Support Services Outreach & MH Navigator, RIST; Canadian Mental Health Association, Hamilton Branch		8:00am-4:00pm (RN and Peer Support Worker) 8:00am-4:00pm RIST MH worker	8:00am-4:00pm RIST MH worker 10:30am-12:30pm @ Carole Anne's Place (RN), 1:00pm-4:00pm @ CMHA (RN)	8:00am-4:00pm RIST MH worker	8:00am-4:00pm (RN and Peer Support Worker) 8:00am-4:00pm RIST MH worker		

Provider Name	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
St Matthew's/City of Hamilton - Housing Focused Street Outreach	8:00am-8:00pm	8:00am-8:00pm	8:00am-8:00pm	8:00am-8:00pm	8:00am-8:00pm	8:00am-4:00pm	8:00am-4:00pm
De dwada dehs nye>s Aboriginal Health Centre Mobile Medical Clinic	10am to 3pm		Drop in clinic (time data missing)	10am to 3pm	10am to 3pm		
Good Shepherd Health on Wheels Mobile Health Clinic	9:00am-3:30pm	9:00am-3:30pm	9:00am-3:30pm	9:00am-3:30pm	9:00am-3:30pm		
Hamilton Midwives Outreach Team	24/7	24/7	24/7	24/7	24/7	24/7	24/7
HAMSMaRT / Keeping Six		1pm-3pm Drop In	Workshops offered between 2pm-5:30pm at various locations				
Wayside House of Hamilton - HepC Outreach Team	8am-4pm	8am-4pm	8am-4pm	8am-4pm	8am-4pm		
Hamilton Health Sciences - Hospital 2 Home	8am-4pm	8am-4pm	8am-4pm	8am-4pm	8am-4pm		
Hamilton Regional Indian Center - Mobile Street Outreach	11:00am-7:00pm	11:00am-7:00pm	11:00am-7:00pm	11:00am-7:00pm	11:00am-7:00pm		

Hamilton Police Service - Social Navigator Program(SNP) & Rapid Intervention and Support Team (RIST)	SNP (Medics): 7am-7pm SNP (Officers): 8am-6pm RIST: 8:30am-4:30pm	SNP (Medics): 7am-7pm SNP (Officers): 8am-6pm RIST: 8:30am-4:30pm	SNP (Medics): 7am-7pm SNP (Officers): 8am-6pm RIST: 8:30am-4:30pm	SNP (Medics): 7am-7pm SNP (Officers): 8am-6pm RIST: 8:30am-4:30pm	SNP (Medics): 7am-7pm SNP (Officers): 8am-6pm RIST: 8:30am-4:30pm	SNP (Medics): 7am-7pm SNP (Officers): 8am-6pm	SNP (Medics): 7am-7pm SNP (Officers): 8am-6pm
Provider Name	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
The Hub - Street Outreach Clinics	Monday - 1:00pm-4:00pm street health clinic & 5pm-9pm drop in Operate 24/7 for youth ages 17-27 for gun and gang related violence interruption and crisis response.	1:00pm-4:00pm primary care health clinic by Shelter Health partners & drop in 5:00pm-9:00pm Operate 24/7 for youth ages 17-27 for gun and gang related violence interruption and crisis response.	1:00pm-4:00pm primary care health clinic by Shelter Health partners & drop in 5:00pm-9:00pm Operate 24/7 for youth ages 17-27 for gun and gang related violence interruption and crisis response.	1:00pm-4:00pm primary care health clinic by Shelter Health partners & drop in 5:00pm-9:00pm Operate 24/7 for youth ages 17-27 for gun and gang related violence interruption and crisis response.	1:00pm-4:00pm primary care health clinic by Shelter Health partners & drop in 5:00pm-9:00pm Operate 24/7 for youth ages 17-27 for gun and gang related violence interruption and crisis response.	Drop in for youth only We operate 24/7 for youth ages 17-27 for gun and gang related violence interruption and crisis response. Operate 24/7 for youth ages 17-27 for gun and gang related violence interruption and crisis response.	
City of Hamilton Public Health Services - Harm Reduction Program	Harm Reduction Team 8:30am-4:30pm VAN 7pm-11pm	Harm Reduction Team 8:30am-4:30pm VAN 7pm-11pm	Harm Reduction Team 8:30am-4:30pm VAN 11:00am-3:00pm and 7pm-11pm	Harm Reduction Team 8:30am-4:30pm VAN 11:00am-3:00pm and 7pm-11pm	Harm Reduction Team 8:30am-4:30pm VAN 7pm-11pm	VAN 7pm-11pm	VAN 7pm-11pm
City of Hamilton Public Health Services - Mental Health and Street Outreach Program	9:00am-5:00pm - outreach staff Social work at	9:00am-5:00pm - outreach staff Social work at	9:00am-5:00pm - outreach staff Social work at	9:00am-5:00pm - outreach staff Social work at	9:00am-5:00pm - outreach staff Social work at	Social work every other Saturday at library location	

	HPL various drop in times	HPL various drop in times	HPL various drop in times	HPL various drop in times	HPL various drop in times		
Provider Name	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Good Shepherd RAAM - Mobile and Community-Based Program	9:00am - 5:00pm	9:00am - 5:00pm	9:00am - 5:00pm	9:00am - 5:00pm	9:00am - 5:00pm		
St. Joseph's Healthcare Hamilton - Hospital 2 Home	8am-4pm	8am-4pm	8am-4pm	8am-4pm	8am-4pm		
Wesley Provincial Youth Outreach Workers Hamilton/Brantford	the PYOW team will flex their schedule to support and meet the needs of the youth they support.	12pm-8pm	12pm-8pm	12pm-8pm	12pm-8pm	12pm-8pm	
YWCA Emergency Reproduction Care - Mobile	Varying times 24/7 for ERCB beds	Varying times 24/7 for ERCB beds	Varying times 24/7 for ERCB beds	Varying times 24/7 for ERCB beds	Varying times 24/7 for ERCB beds	24/7 for ERCB beds	24/7 for ERCB beds
Shelter Health Network	8:00am-4:00pm across multiple clinic locations	8:00am-4:00pm across multiple clinic locations	8:00am-4:00pm across multiple clinic locations	8:00am-4:00pm across multiple clinic locations	8:00am-4:00pm across multiple clinic locations		
The AIDS Network - Hamilton & Haldimand*	Missing Data						

Table 16: Service Delivery Schedules for Hamilton Providers. Note: Wesley Provincial Youth Outreach Workers Hamilton/Brantford: the PYOW team will flex their schedule to support and meet the needs of the youth they support.

Provider Name	Direct Access	Referral Access	Self-Referral Accepted
CMHA Street Team, Peer Support Services Outreach & MH Navigator, RIST; Canadian Mental Health Association, Hamilton Branch	X	X	X
St Matthew's/City of Hamilton - Housing Focused Street Outreach	X	X	
De dwada dehs nye>s Aboriginal Health Centre Mobile Medical Clinic	X		
Good Shepherd Health on Wheels Mobile Health Clinic	X	X	X
Hamilton Midwives Outreach Team		X	
HAMSMaRT / Keeping Six	X	X	X
Wayside House of Hamilton - HepC Outreach Team	X	X	X
Hamilton Health Sciences - Hospital 2 Home		X	
Hamilton Regional Indian Center - Mobile Street Outreach	X		
Hamilton Police Service - Social Navigator Program(SNP) & Rapid Intervention and Support Team (RIST)	X	X	X
The Hub - Street Outreach Clinics	X	X	X
City of Hamilton Public Health Services - Harm Reduction Program	X		
City of Hamilton Public Health Services - Mental Health and Street Outreach Program	X	X	X
Good Shepherd RAAM - Mobile and Community-Based Program	X	X	
St. Joseph’s Healthcare Hamilton - Hospital 2 Home		X	
Wesley Provincial Youth Outreach Workers Hamilton/Brantford		X	
YWCA Emergency Reproduction Care - Mobile		X	X

Provider Name	Direct Access	Referral Access	Self-Referral Accepted
Shelter Health Network	X	X	X
The AIDS Network - Hamilton & Haldimand*	X		

Table 17: Service Access Models for Hamilton Providers.

Additional Service Accessibility Information:

- St Matthew's/City of Hamilton - Housing Focused Street Outreach: Referrals accepted from any/all sources.
- Hamilton Midwives Outreach Team: Our pager number should be available to all frontline social service works who can reach us on behalf of clients utilizing shelters, drop-in centres, encampments, etc. There is no official referral form or process and service users can request that a worker contacts us on their behalf at any time. We hesitate to give our number out more freely to individuals who require our service because our program is volunteer based with midwives that are often on call for other work and should only be contacted when necessary.
- The Hub: Accepts peer referrals.
- Shelter Health Network: Hep C uses referral forms.

Data Interpretation of Service Delivery Models and Operational Hours in Hamilton:

Service Delivery Diversity and Extensiveness - Providers such as St. Matthew's/City of Hamilton and The Hub offer extended hours, including evenings and weekends, enhancing accessibility for those with fixed or unconventional work schedules. Hamilton Midwives Outreach Team provides 24/7 availability for urgent maternal and reproductive health needs, emphasizing their commitment to accessible care at all times.

Focused Service Hours and Specialized Programs - Organizations like HAMSMaRT / Keeping Six and Good Shepherd Health on Wheels offer focused service hours and specialized programs tailored to the needs of specific demographics, such as individuals using substances or requiring mobile health services. De dwada dehs nye>s Aboriginal Health Centre offers targeted clinic times designed to maximize resource efficiency and patient turnout.

Gaps in Service Times and Potential Overlaps - A lack of service time information for some providers, including The AIDS Network, may hinder effective access to these services. Overlaps in service times among providers focusing on similar populations could indicate both a robust response to community needs and potential redundancies.

Access Models and Referral Systems - Direct access is prevalent across many providers like CMHA and Good Shepherd Health on Wheels, reducing barriers to service utilization. Varied referral requirements indicate a need for greater uniformity in access pathways to enhance user understanding and engagement.

Strategic Implications:

- **Enhanced Coordination**: Opportunities exist for providers to coordinate service times and refine access models to cover gaps, especially during off-peak hours or weekends.
- **Streamlined Referral Processes**: Standardizing referral processes could significantly improve the efficiency and patient experience, particularly for urgent care services.
- **Data Transparency and Availability**: Enhancing the availability and transparency of service schedules and access information would aid in community planning and empower individuals to make informed health care decisions.

3.3.4 Funding Sources

In Hamilton, the funding landscape for healthcare providers offering outreach and mobile health services is characterized by a strong reliance on diversified funding sources. This diverse funding ecosystem enables Hamilton's healthcare providers to deliver comprehensive, tailored services across the community, ensuring that both general and specialized needs are met. However, there are potential challenges and opportunities present.

The data collected on sources of funding for mobile and outreach services in Hamilton is outlined in the figure, charts, and summary below.

Publicly Funded

- City of Hamilton Harm Reduction
- Hamilton Police SNP RIST
- Hamilton Health Sciences Hospital 2 Home
- Good Shepherd Health On Wheels
- St Matthews
- City of Hamilton Mental Health and Street Outreach
- YWCA Emergency Reproduction Care – Mobile

Diversified Funding, Including Public and Targeted Funds

- HAMSMaRT/Keeping Six
- CMHA Street Team, Peer Support Services Outreach & MH Navigator, RIST
- De dwada dehs nye>s Aboriginal Health Centre Mobile Medical Clinic
- The Hub - Street Outreach Clinics
- Shelter Health Network
- Wesley Provincial Youth Outreach Workers Hamilton/Brantford
- The AIDS Network - Hamilton & Haldimand*
- Hamilton Regional Indian Center - Mobile Street Outreach
- Good Shepherd RAAM - Mobile and Community-Based Program
- St. Joseph's Healthcare Hamilton - Hospital 2 Home
- Wayside House of Hamilton - HepC Outreach Team

Community Sponsored

- Hamilton Midwives Outreach: Funded through community sponsorship, with one-time funding in 2022 from the Hamilton Community Foundation. The funds are exclusively used for clients, not for payment to midwives.

Figure 4: Funding Sources for Hamilton Providers

Potential Challenges with Funding

Dependency on Public Funding	• **Sustainability Risk**: Providers primarily funded by public sources may face risks related to budget cuts or policy changes that can abruptly affect their funding. This dependency could limit their operational flexibility and responsiveness to emerging needs. • **Regulatory Constraints**: Public funding often comes with stringent regulations and oversight, which might restrict how services can innovate or expand.

Diversified Funding Complexity	• **Management Overhead**: Managing diversified funding sources can be administratively burdensome and complex, requiring sophisticated financial management systems and expertise. • **Inconsistent Funding Streams**: Reliance on multiple funding sources may lead to inconsistent financial inflows, affecting the predictability and stability needed for long-term planning and service delivery.
Community-Sponsored Limitations	• **Scalability**: Funding from community sponsorships or one-time grants, like those supporting Hamilton Midwives Outreach, are often not sustainable for scaling services or planning long-term due to their temporary nature. • **Volatility**: Community-sponsored funding can be highly volatile, depending largely on local economic conditions and community goodwill, which may fluctuate.

Table 18: Opportunities to Strengthen Funding in Hamilton.

Opportunities to Strengthen Funding

Leveraging Public and Private Partnerships	• **Increased Resources**: Building partnerships with private donors, local businesses, and non-profits can supplement public funds, providing a more robust financial base. • **Innovation and Flexibility**: Partnerships with private entities often allow for more innovative approaches due to fewer regulatory constraints compared to public funding.
Expanding Targeted Funding Opportunities	• **Specialized Services**: Pursuing targeted funds for special populations can help providers expand or enhance services specifically tailored to meet unique community needs, such as those offered by HAMSMaRT/Keeping Six. • **Grant Applications**: Actively seeking out grants that align with the organization's mission can support specific projects or expansions that regular funding does not cover.
Enhancing Community Engagement for Sponsorship	• **Community Partnerships**: Strengthening relationships with community organizations can lead to more sustained support and potentially unlock new funding avenues.
Advocacy for Stable Public Funding	• **Policy Advocacy**: Engaging in advocacy work to influence public funding policies can help secure more stable and adequate funding allocations for healthcare services. • **Demonstrating Impact**: By systematically collecting data on service impact and effectively communicating these outcomes, providers can make a stronger case for continued or increased public investment.

Table 19: Opportunities to Strengthen Funding in Hamilton.

While the current funding landscape in Hamilton provides a solid foundation for delivering diverse healthcare services, providers could benefit from exploring additional funding strategies to mitigate risks and capitalize on opportunities for growth and sustainability.

This could involve enhancing their funding mix, engaging more deeply with potential community funders, and actively participating in policy discussions that affect healthcare funding.

3.3.5 Partnerships, Staffing Models, and Evaluation Metrics

The data collected on partnerships, staffing models and evaluation metrics in Hamilton is outlined in the figures, table, and summary below.

Provider Name	Partners (exclusive partnerships are bolded)
CMHA Street Team, Peer Support Services Outreach & MH Navigator, RIST; Canadian Mental Health Association, Hamilton Branch	1. Shelter Health Network **2. 541** 3. YWCA 4. Public Health Services 5. Hamilton's Rapid Intervention Support Team (consisting of 5+ cross-sector partners)
St Matthew's/City of Hamilton - Housing Focused Street Outreach	1. Hamilton Regional Indian Center 2. Also work closely with other City programs - Public Health, MLE, HPS, Public Works, etc
De dwada dehs nye>s Aboriginal Health Centre Mobile Medical Clinic	Missing Data
Good Shepherd Health on Wheels Mobile Health Clinic	1. Shelter Health Network 2. Hamilton Street Outreach 3. Social Navigator Program
Hamilton Midwives Outreach Team	1. Shelter Health Network **2. Crown Point Midwives** **3. Birthmark doulas**
HAMSMaRT / Keeping Six	1. YWCA 2. CMHA 3. Good Shepherd
Wayside House of Hamilton - HepC Outreach Team	1. Shelter Health Network **2. Charlton Health** **3. The AIDS & Hepatitis C Secretariat** **4. Six Nations of the Grand River** 5. **New Credit Frist Nations** 6. Good Shephard (Notre Dame, Men's Shelter, Dorothy Day) 7. Mission Services (Willow's Place, Men's Shelter, Suntrac)

	8. Salvation Army Men's Center, **9. Stipley Methadone Clinic** **10. Segue Methadone Clinic** 11. St Joseph's Hopsital MASH & Womankind 12. Hamilton Regional Indian Center 13. Urban Core **14. St Patrick's Church** **15. Club Hamilton** 16. **Mohawk College**
Provider Name	Partners (exclusive partnerships are bolded)
Hamilton Health Sciences - Hospital 2 Home	HHS partners with one community partner (provides funding for community health navigators) HHS partners with many partners to develop integrated coordinated care plans
Hamilton Regional Indian Center - Mobile Street Outreach	Missing Data
Hamilton Police Service - Social Navigator Program(SNP) & Rapid Intervention and Support Team (RIST)	1. Wesley 2. St Joes 3. CMHA **4. Interval House** 5. YMCA 6. Hamilton Regional Indian Center 7. JHS
The Hub - Street Outreach Clinics	1. Shelter Health Network 2. **Ontario Trillium Foundation** and Wesley 3. Hamilton Public Health Services **4. McMaster University** **5. Hamilton Family Health Team** **6. SPRC** 7. Many informal partnerships.
City of Hamilton Public Health Services - Harm Reduction Program	1. The AIDS Network 2. Mission Services 3. The Hub 4. YWCA **5. Living Rock** 6. Good Shepherd 7. Hamilton Urban Core

	8. Salvation Army **9. SOPEN** 10. Shelter Health Network
Provider Name	Partners (exclusive partnerships are bolded)
City of Hamilton Public Health Services - Mental Health and Street Outreach Program	1. Hamilton Public Library 2. The AIDS Network 3. Mission Services **4. Housing Help Centre**
Good Shepherd RAAM - Mobile and Community-Based Program	1. Good Shepherd Programs 2. The Shelter Health Network 3. Mission Services
St. Joseph's Healthcare Hamilton - Hospital 2 Home	Significant collaborations with any agencies/supports which patients need. With consent engage with medical specialists, Primary Care providers, HCCSS, developmental services, housing and shelter providers, mental health providers, income assistance programs, legal services and others including refugee and newcomer services.
Wesley Provincial Youth Outreach Workers Hamilton/Brantford	No partners were listed.
YWCA Emergency Reproduction Care - Mobile	**1. Birth Mark** 2. **PROSPR**
Shelter Health Network	1. YWCA 2. The Hub 3. Womankind 4. Mission Services 5. Notre Dame **6. Vanier Towers** 7. Wesley 8. Wayside 9. The Hamilton Clinic 10. Men's Addiction Services **11. Youth Wellness Centre** 12. CMHA Street Team, Peer Support Services Outreach & MH Navigator, RIST 13. Salvation Army 14. Good Shepherd Health on Wheels 15. Good Shepherd RAAM

	16. Indwell 17. City of Hamilton – Harm Reduction Program 18. Hamilton Midwives Outreach team
The AIDS Network - Hamilton & Haldimand*	Missing Data

Table 20: Partners Listed by Hamilton Providers.

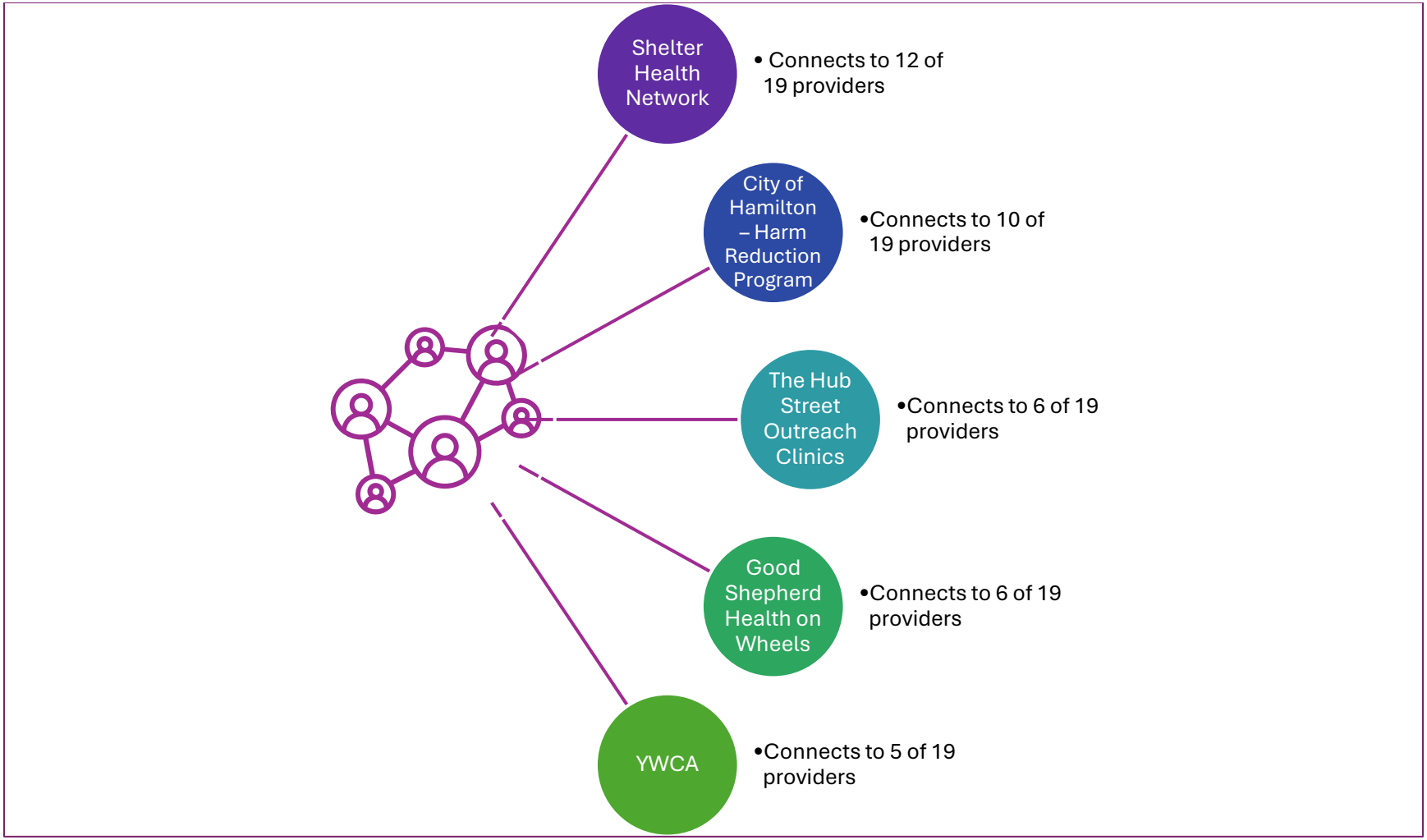


Figure 5: Network Integration: Cross-Provider Collaborations Among Hamilton Service Providers

Data Interpretation of Partnerships:

Hamilton currently has a robust yet complex network of collaboration that, if strategically harnessed, could significantly enhance the effectiveness and reach of health and social services in the region.

Observations:

- Most partnerships are reciprocated where data is available, indicating a strong interconnection among service providers in Hamilton.
- Some providers like **De dwada dehs nye>s Aboriginal Health Centre Mobile Medical Clinic** and **The AIDS Network - Hamilton & Haldimand** have missing partnership data, so the extent of their collaborations isn't clear.
- **Shelter Health Network** emerges as the most central partner, supporting a wide range of services and providers, indicating its pivotal role in Hamilton's health outreach service ecosystem.
- **Good Shepherd**, **The Hub**, **YWCA**, and **Hamilton Public Health's Harm Reduction Program** also play significant roles, each connecting with multiple providers to offer a variety of health and social services.
- **City programs** and some health services mention "many informal partnerships," which suggests broader, not explicitly listed collaborations that likely include other mentioned providers.

Analysis:

- **Multiple Providers with Similar Partners**: Several organizations list common partners such as the Shelter Health Network and Good Shepherd. This overlap indicates a central cluster of resources within the community but also raises questions about potential redundancies in services provided. An in-depth evaluation could assess whether these overlaps enhance service delivery through strengthened networks or if they lead to inefficiencies.
- **Broad Spectrum Collaboration**: The widespread nature of these partnerships across different sectors (healthcare, social services, emergency services) suggests that there is already a substantial foundation for integrated care. However, ensuring that these collaborations are effectively managed and coordinated is essential to prevent service fragmentation and to maximize the benefits of a united approach.

Strategic Implications

- **Enhanced Coordination of Services**: With overlaps in partnerships, there is a significant opportunity to enhance the coordination of services across organizations. Establishing more formal cooperative agreements or joint ventures could streamline services, reduce duplication, and extend resource utilization efficiency.
- **Resource Sharing and Joint Funding Initiatives**: Given the overlaps in funding sources and partners, organizations could benefit from developing joint funding proposals that leverage their collective strengths, potentially increasing their impact and the sustainability of their programs.

Provider Name	Regulated Health Professional Roles (FTE)	Non-Regulated Roles (FTE)	Notes
CMHA Street Team, Peer Support Services Outreach & MH Navigator, RIST; Canadian Mental Health Association, Hamilton Branch	1.5	0.5	
St Matthew's/City of Hamilton - Housing Focused Street Outreach	0	13	
De dwada dehs nye>s Aboriginal Health Centre Mobile Medical Clinic	2	1	
Good Shepherd Health on Wheels Mobile Health Clinic	2	3	
Hamilton Midwives Outreach Team	8*	0	*8 Registered Midwives and a physician lead on our team but the work is volunteer based and none of the members are doing this work full time.
HAMSMaRT / Keeping Six	Missing Data		Mostly volunteer peer support
Wayside House of Hamilton - HepC Outreach Team	2	2	

Provider Name	Regulated Health Professional Roles (FTE)	Non-Regulated Roles (FTE)	Notes
Hamilton Health Sciences - Hospital 2 Home	6	5	
Hamilton Regional Indian Center - Mobile Street Outreach	0	3	
Hamilton Police Service - Social Navigator Program(SNP) & Rapid Intervention and Support Team (RIST)	9	11	
The Hub - Street Outreach Clinics	3	50*	50 volunteers (not FTE)
City of Hamilton Public Health Services - Harm Reduction Program	5.5	3	
City of Hamilton Public Health Services - Mental Health and Street Outreach Program	1.5	4	
Good Shepherd RAAM - Mobile and Community-Based Program	1	0	
St. Joseph's Healthcare Hamilton - Hospital 2 Home	2	1	
Wesley Provincial Youth Outreach Workers Hamilton/Brantford	0	5	
YWCA Emergency Reproduction Care - Mobile	0	1	
Shelter Health Network	3.5	0	
The AIDS Network - Hamilton & Haldimand*	Missing Data		

Table 21: Staffing Models for Hamilton Providers.

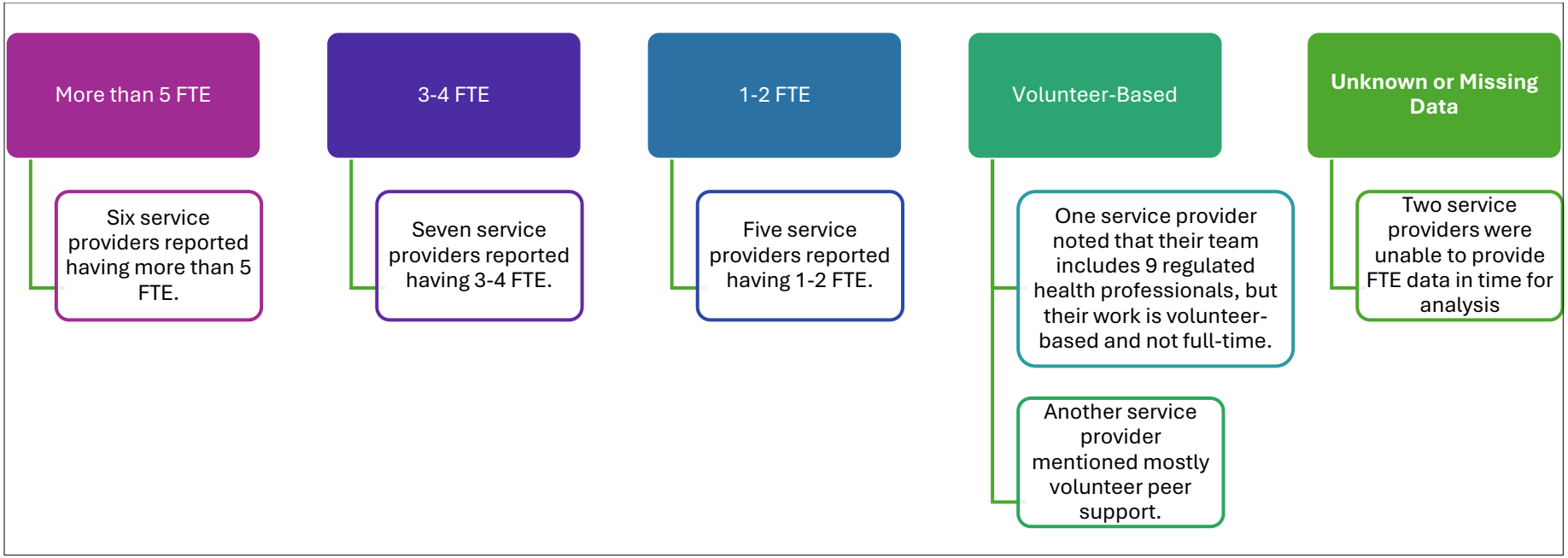


Figure 6: Summary of FTE for Outreach and Mobile Services in Hamilton.

Data Interpretation of Staffing Models in Hamilton:

Diverse Staffing Structures:The staffing models vary widely across providers, from volunteer-based teams to significant numbers of regulated health professionals and non-regulated support staff. This diversity in staffing reflects different operational focuses and the variety of services offered.

Heavy Reliance on Non-Regulated Support: Several providers, notably St Matthew's/City of Hamilton and The Hub - Street Outreach Clinics, rely heavily on non-regulated roles, including a large number of volunteers, indicating a community-driven approach to service delivery. This model may enhance accessibility and relatability for service users but might also face challenges in maintaining professional healthcare delivery standards without a proportionate number of regulated staff.

Regulated vs. Non-Regulated Staff: Some organizations, like the Hamilton Police Service - Social Navigator Program and Hamilton Health Sciences - Hospital 2 Home, maintain a balanced mix of regulated and non-regulated staff, ensuring a robust service model that combines professional healthcare with supportive care roles.

Volunteer Involvement - Organizations such as HAMSMaRT / Keeping Six and Hamilton Midwives Outreach Team highlight the significant role of volunteer peer support and volunteer midwives. This not only helps in extending service reach without proportional cost increases but also embeds services within the community, fostering trust and engagement.

Challenges in Data Availability - Missing data from providers like HAMSMaRT / Keeping Six and The AIDS Network - Hamilton & Haldimand underscore the challenges in fully assessing the resource allocation and potential gaps in staffing needs.

Focus on Marginalized Populations - The staffing allocation often targets services at highly marginalized groups such as those with substance use issues, the homeless, and indigenous communities. The presence of dedicated outreach and support staff for these groups reflects an acknowledgment of their unique needs and the importance of specialized interventions.

Strategic Implications

- **Enhancing Staff Sustainability**: For organizations relying heavily on volunteers or facing data gaps, there is an opportunity to explore more sustainable staffing models that might include seeking additional funding for regulated roles or developing incentives for long-term volunteer engagement.
- **Collaboration and Coordination**: Given the overlap in target populations and the varied staffing models, there is substantial scope for increased collaboration and coordination between organizations. This could help in sharing best practices, training resources, and even staffing resources to cover gaps in service provision.

Provider Name	Feedback from diverse populations	Service utilization and reach metrics	Impact on community health and well-being	Notes
CMHA Street Team, Peer Support Services Outreach & MH Navigator, RIST; Canadian Mental Health Association, Hamilton Branch	X	X	X	Provider experience, number of Naloxone kits and harm reduction supplies distributed
St Matthew's/City of Hamilton - Housing Focused Street Outreach	X	X		
De dwada dehs nye>s Aboriginal Health Centre Mobile Medical Clinic		X		Despite missing data, assumption has been made that some level of service utilization is collected by the provider organization

Provider Name	Feedback from diverse populations	Service utilization and reach metrics	Impact on community health and well-being	Notes
Good Shepherd Health on Wheels Mobile Health Clinic		X		
Hamilton Midwives Outreach Team		X		
HAMSMaRT / Keeping Six	X	X		
Wayside House of Hamilton - HepC Outreach Team		X		
Hamilton Health Sciences - Hospital 2 Home	X	X		
Hamilton Regional Indian Center - Mobile Street Outreach		X		Despite missing data, assumption has been made that some level of service utilization is collected by the provider organization
Hamilton Police Service - Social Navigator Program(SNP) & Rapid Intervention and Support Team (RIST)	X	X		
The Hub - Street Outreach Clinics	X	X	X	Tracking based on Ontario Trillium Foundation grant requirements. OTF funds ONLY our youth program.
City of Hamilton Public Health Services - Harm Reduction Program	X	X	X	
City of Hamilton Public Health Services - Mental Health and Street Outreach Program		X	X	
Good Shepherd RAAM - Mobile and Community-Based Program		X		
St. Joseph's Healthcare Hamilton - Hospital 2 Home		X		

Provider Name	Feedback from diverse populations	Service utilization and reach metrics	Impact on community health and well-being	Notes
Wesley Provincial Youth Outreach Workers Hamilton/Brantford		X		
YWCA Emergency Reproduction Care - Mobile		X		
Shelter Health Network		X		
The AIDS Network - Hamilton & Haldimand*		X		Despite missing data, assumption has been made that some level of service utilization is collected by the provider organization

Table 22: Evaluation Metrics Used by Hamilton Providers.

Data Interpretation on Metrics of Success in Hamilton:

Comprehensive Tracking - Organizations like CMHA Street Team, The Hub - Street Outreach Clinics, and City of Hamilton Public Health Services stand out for their comprehensive tracking of feedback from diverse populations, service utilization, and direct impacts on community health and well-being. This multi-dimensional approach allows these providers to gauge the effectiveness of their services holistically and make informed adjustments.

CMHA Street Team notes specific indicators such as provider experience and the distribution of Naloxone kits and harm reduction supplies, which are crucial for understanding the immediate utility and impact of their outreach efforts.

Focused Feedback and Utilization - Providers like Hamilton Police Service's Social Navigator Program and HAMSMaRT / Keeping Six collect feedback directly from the populations they serve, which is vital for tailoring services to real-world needs and experiences.

Service Utilization Metrics: All of the providers track service utilization to some extent, though the specifics of these metrics vary and are sometimes not fully detailed. This tracking helps in understanding reach and demand but needs to be coupled with impact measures for a full assessment.

Gaps in Impact Measurement - For some providers like De dwada dehs nye>s Aboriginal Health Centre and Hamilton Regional Indian Center, there is an assumption of basic service utilization tracking without specific data provided. This indicates a potential gap in transparent and detailed reporting of how services affect community health.

Several organizations, including Good Shepherd RAAM and St. Joseph's Healthcare Hospital 2 Home, report service utilization but lack specific metrics on the impact on community health, suggesting an area for development in their evaluation frameworks.

Specialized Tracking Based on Funding Requirements - The Hub's tracking methods are influenced by the requirements of the Ontario Trillium Foundation grant, highlighting how external funding sources can dictate what and how outcomes are measured. This can ensure focused accountability but may also restrict the scope of what is tracked to the grantor's interests.

Strategic Implications

- **Need for Integrated Metrics Systems**: There is a clear need for more integrated and comprehensive metrics systems that not only track service utilization but also directly measure the impact on community health and well-being. Such systems should be standardized across services where possible to facilitate comparisons and benchmarking.
- **Enhancing Feedback Mechanisms**: Increasing the mechanisms for receiving and integrating feedback from diverse populations can help tailor services more effectively to meet specific community needs and enhance user satisfaction.

In conclusion, while Hamilton's healthcare providers employ a range of methods to track the success of their outreach and mobile services, enhancing the depth, breadth, and integration of these metrics will be crucial for comprehensively understanding and improving the health outcomes for the community they serve.

4.0 Recommendations

Based on the data available for this current state analysis of mobile and outreach service delivery in the Greater Hamilton Health Network's catchment area, the following strategic recommendations have been developed.

1. **Enhance Service Integration and Coordination:** Develop and implement cohesive health and social service models across all regions, ensuring that these models include effective mechanisms for referrals and shared care plans. This should involve standardizing processes for integrating services across different providers to ensure seamless patient experiences and continuity of care. Establish joint protocols and inter-agency agreements to solidify the collaboration framework.
2. **Optimize Collaborative Networks:** Strengthen the foundation of collaborative networks by establishing formal partnerships among service providers. This involves setting up regular inter-agency meetings, joint training sessions, and shared funding initiatives to enhance resource utilization and deliver comprehensive care. Facilitate community stakeholder forums to engage all relevant parties in ongoing service design and improvement.

3. **Advance Policy Advocacy and Regular Service Mapping:** Actively participate in policy advocacy to influence health and social service policies that support integrated service models. Regularly conduct comprehensive service mappings to identify service gaps and overlaps, adapting the service delivery to meet the evolving needs of the community. This should include an annual review of service impact against community health outcomes to inform policy adjustments.
4. **Implement a Coordinated, Centralized Dispatch System:** Establish a centralized dispatch system to coordinate mobile and outreach services, ensuring efficient resource allocation and service delivery. This system should feature scheduling software and real-time data capabilities to reduce service redundancy and optimize coverage across geographical areas. The system could also integrate with local emergency services to ensure a coordinated response when needed.
5. **Data Transparency and Systematic Collection:** Upgrade data collection processes to ensure robust, real-time data is available on service utilization, patient outcomes, and operational effectiveness. Implement advanced data analytics tools to analyze trends and performance, facilitating strategic decision-making. Ensure that data collection systems are compliant with privacy regulations and are capable of integrating with broader health information systems.
6. **Establish Consistent Evaluation Metrics:** Develop and implement standardized evaluation metrics across all services to consistently assess and compare the effectiveness, quality, and impact of healthcare provisions. These metrics should be aligned with GHHN performance standards and tailored to local service objectives, facilitating benchmarking and performance improvement.
7. **Create a Coordinator Role:** If feasible, introduce a coordinator or knowledge broker role to facilitate knowledge exchange, enhance collaborative opportunities, and improve funding and staffing models among providers. This role could focus on fostering strategic partnerships, aligning resources effectively, and ensuring that innovations and service improvements are systematically integrated across the network.