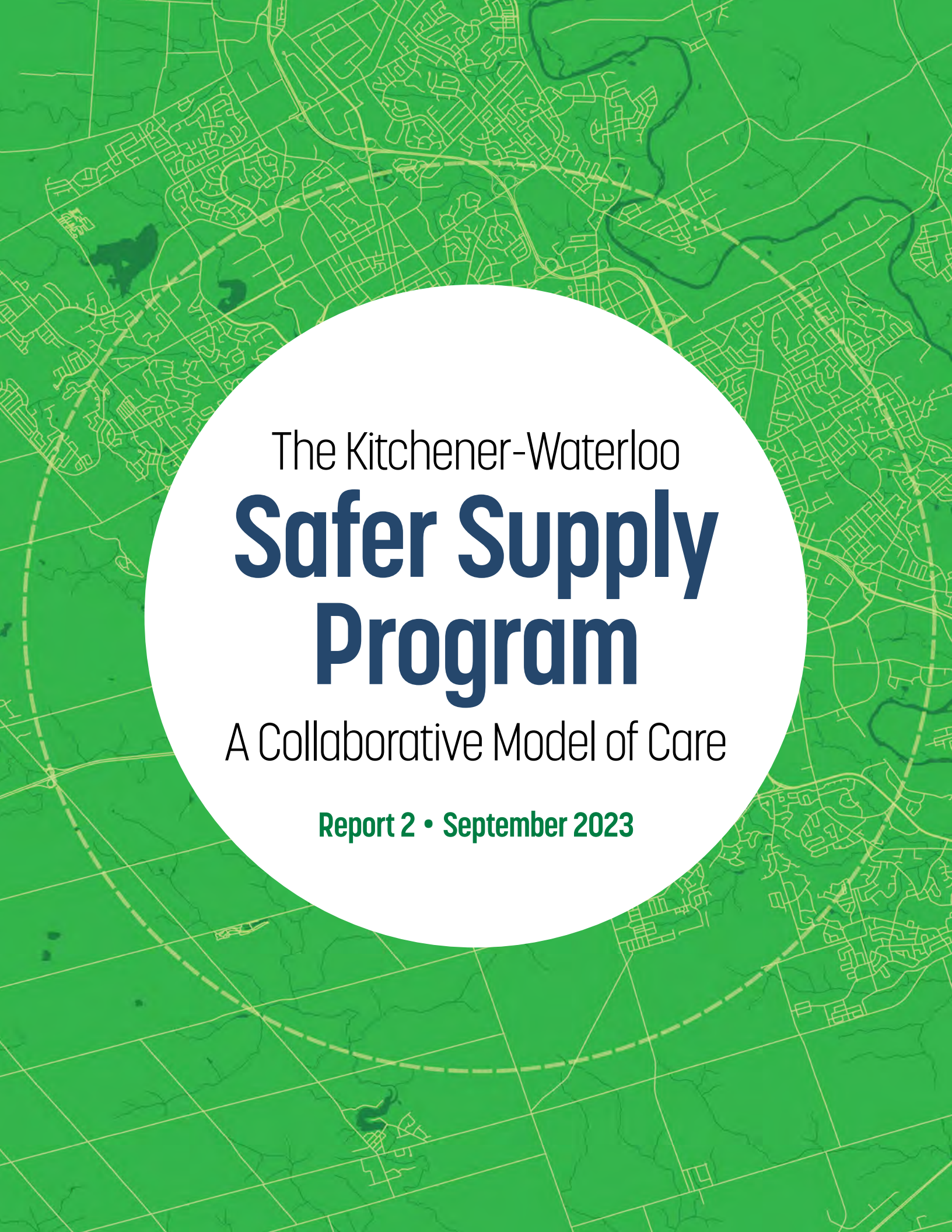

The Kitchener-Waterloo

Safer Supply Program

A Collaborative Model of Care

Report 2 • September 2023

Evaluation Team

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Introduction

Over 32,600 deaths due to opioid toxicity have been recorded in Canada between January 2016 and June 2022 [1]. The onset of COVID-19 in March 2020 exacerbated the impacts of the unregulated and highly toxic drug supply on overdose rates nationwide. In Ontario, there was a 79% increase in the overall number of opioid-related deaths and a 129% increase in the number of overdose deaths among people experiencing homelessness between February and December 2020 [2]. Safer supply programs – where pharmaceutical medications are prescribed to people to reduce their reliance on the unregulated drug supply - is one intervention aimed at mitigating impacts related to the increasingly potent market of fentanyl, fentanyl analogues, and unregulated benzodiazepines [3].

In response to the intensifying crisis of dual public health emergencies, Health Canada funded 25 safer supply pilot programs across Canada under the Substance Use and Addiction Program (SUAP) [4]. In Kitchener-Waterloo, the Inner-City Health Alliance (ICHA) received SUAP funding in 2021 to implement a Safer Supply Program (SSP). Since then, the SSP has been delivered as a wraparound health care and harm reduction service within the ICHA using a collaborative care model.

This report is the second part of an evaluation of the SSP in the Kitchener-Waterloo region, which is operated through a partnership of several organizations that are members of the ICHA. The first report contains details on the structure of the SSP and the program outcomes for clients [5]. This second report describes the unique collaborative care model developed for this SSP, its strengths and challenges, and provides recommendations for improving the collaborative care provided to SSP clients. This report uses qualitative data collected in the summer of 2022 from 22 SSP clients and 22 service providers from organizations that form part of the ICHA. Service providers included: prescribers (physicians and nurse practitioners), nurses, care facilitators, system navigators, and outreach and harm reduction workers. The 22 service providers interviewed comprised two groups:

- 13 internal service providers who were Sanguen Health Centre staff members and whose direct role was provision of SSP (referred to as internal providers in this report);
- 9 external service providers who were staff members employed by partner organizations who worked in collaboration with the SSP, but provision of SSP was not their direct role (referred to as external providers in this report).

More details on the methods are provided in the Methods Appendix found at the end of this report.

The Safer Supply Program and the Collaborative Care Model

The primary focus of this community-led SSP is flexible, low-barrier access to pharmaceutical opioids through a health equity and harm reduction lens. Beyond a prescription, SSP clients are supported by an interdisciplinary team of physicians, nurse practitioners, nurses, social workers, and community navigators who provide wrap-around care to clients using a harm reduction, trauma-informed, and person-centered approach. The value of this approach to service delivery has been well-established given the histories of complex trauma and harm faced by people who use drugs [6].

A variety of different models are currently being used for safer supply delivery across Canada. Models include the delivery of safer supply through community health centres [7,8] , within supportive housing settings [9], in existing supervised consumption sites and addiction medicine practices [10], using biometric dispensing machines [11], as well as prescribing that occurred using risk mitigation guidelines to facilitate COVID-related isolation in the pandemic period [12–14]. Evaluations of these models have demonstrated a range of benefits including reductions in use of fentanyl from unregulated sources, reductions in emergency department visits, hospitalizations, and healthcare costs, reduced frequency of injection, and improved physical and mental health and overall stability [7–11,14–16]. This evaluation expands on the existing knowledge base about SSPs in Canada by providing an overview of the Kitchener-Waterloo SSP which is uniquely embedded within the ICHA that includes intensive place-based and mobile primary health care, housing, shelter, and social connections delivered with a caring, person-centred, and evidence-informed approach.

Funding from Health Canada for the SSP is managed by The Working Centre. Individuals living in Kitchener-Waterloo and who are at high risk of overdose from use of unregulated and toxic opioids – mostly fentanyl – are eligible for admission to the program. SSP clients are prescribed pharmaceutical opioids to reduce reliance on unregulated opioids and associated overdose and health risks.

The SSP is being delivered using a collaborative care model. This means that clients of the SSP can access the services available at each of the ICHA partner organizations. The village of services is designed to address the needs of people living in vulnerable conditions, specifically individuals experiencing homelessness and housing insecurity in the Kitchener-Waterloo area of Ontario.

The model of care for the SSP is described as collaborative because:

- It is embedded within the ICHA village of services;
- There is a shared sense of purpose across the agencies;
- Staff within ICHA are knowledgeable about the services available from each organization;
- Staff can easily communicate and leverage services available within the ICHA to better meet client needs;
- The strong presence among partners doing outreach in the community further enables access to a range of services for clients.

The ICHA village of services is comprised of the core community agencies described below in *Table 1.*

Table 1: Overview of Agencies within the Inner City Health Alliance

Agencies	Services Provided
The Working Centre	Hosts Specialized Outreach Services, mobile/concurrent supports that collaborate deeply within the safer supply program, St. John's Kitchen (food and community supports), Street Outreach, 80 units of supportive housing, Hospitality House for those with acute illnesses/palliative care needs, 80 units of interim housing, Job Search Resource Centre, 2 shelters, and emergency motels. Community Tools projects include cafes, used clothing, bicycles, computers, housewares, and furniture.
Sanguen Health Centre	Offers low-barrier hepatitis C testing and treatment, HIV testing and treatment, prescribed safer supply program, counselling, mobile health van, street-based outreach into community settings and encampments. The Sanguen Health Centre is a health-focused outreach organization that meets people where they are to provide primary care, harm reduction, and wrap-around supports.
Kitchener Downtown Community Health Centre (KDCHC)	The Kitchener Downtown Community Health Centre offers comprehensive primary health care, social supports, group supports, and medical and primary care outreach in community settings. Sanctuary Refugee Health Centre is an integral part of the KDCHC.
Centre for Family Medicine Family Health Team	Multi-disciplinary primary care team offering mental health, ambulatory, and outreach services to vulnerable populations, along with education, training, research, and innovation in primary care.
House of Friendship	Provides substance use recovery supports and treatment, supportive housing and shelter, food assistance, and community programming in low-income neighbourhoods
Ray of Hope	Provides programs and services for youth who are experiencing issues with substance use, who are involved in the criminal justice system and have barriers to employment. Also offers programs and services to those who are experiencing poverty and homelessness and newcomers to Canada

Elements of the Collaborative Care Model that are Working Well

SSP clients' comprehensive care needs are met by two organizations, the Sanguen Health Centre and the Downtown Kitchener Community Health Center, which both offer an array of services. The Sanguen Health Centre and the Kitchener Downtown Community Health Center were consistently described as agencies that work closely to support the health and social care needs of clients. When describing the collaboration within the village of services, a health care provider noted:

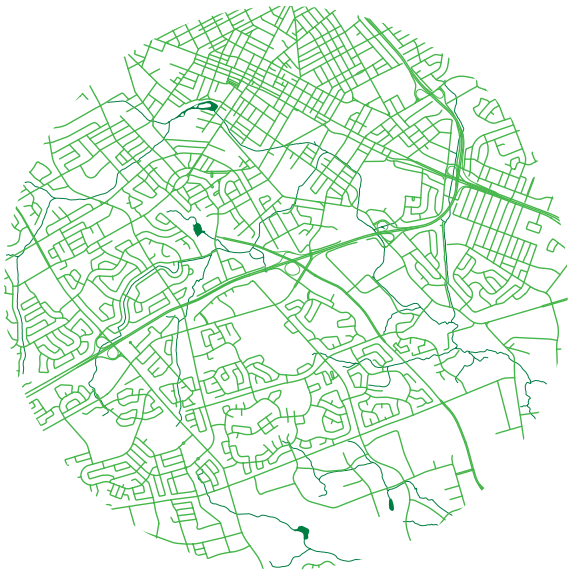
> **"I had somebody who came in and who had not received primary care in 20 years. No drug coverage, wanting to get on ODSP [Ontario Disability Support Program] because they don't qualify for OW, it's a complicated situation. And to get on ODSP, you need a psych consult typically and connection to primary care. So I had this person come in, they needed connection to primary care, someone had a drop-in at the soup kitchen - the nurse practitioner did - so I just brought that person to the drop-in, said 'Hey, this is the situation, can you see them?' They took them on pretty instantly."** (Internal Provider)

The Specialized Outreach Services team run by The Working Centre provides outreach, accompaniment to appointments, transportation, food, social work services, and medical care. Given the heavy burden of homelessness in the community due to the housing affordability crisis, the *"intention of the Specialized Outreach Services team is to bring clinical services to the street level where people are at" (External Provider).* The Specialized Outreach Services team was often mentioned for their role in supporting clients to get to SSP appointments at the Sanguen Health Centre. One provider explained how different agencies get drawn on to complete a client's circle of care:

> **"I find we share a lot of the same clients. To be fair we get a lot of referrals from them. They know community members and then they'll refer them to us. And then work very closely with outreach staff. Say someone from the Working Centre's SOS [Specialized Outreach Services] team has a client that they refer to the Working Centre and their primary care is with KDCHC [Kitchener Downtown Community Health Centre], then we've now become like a circle of care. So, we're constantly now texting and making sure things are happening for those folks."** (External Provider)

There was a common recognition by service providers that supporting clients goes beyond medical care and requires the participation of multiple organizations in the community. Service providers expressed a collective sense of purpose across the ICHA that all would pitch in to support clients, which lessened the pressure on any one provider to know or provide all services:

> **"Everybody seems to have their specialty. It's less information and less stuff for us to hold because everybody else is like the expert in it. We just have to coordinate it all, is what it seems like. Yeah, that's quite helpful because I know that people are going to get the best information."** (Internal Provider)



Secure messaging system enables communication across agencies

Internal and external providers shared that communication across agencies was key to the success of the SSP. Providers across the ICHA described the benefits of using a secure, encrypted and Personal Health Information Protection Act (PHIPPA) approved platform, which allowed individuals from different agencies to message each other and provide collaborative and coordinated support for SSP clients. The ability to confidentially share health information and even clinically relevant pictures in a secure way facilitated efficient medical care:

> **"Generally, we will become aware of a health issue, and then we reach out to our healthcare team through a secure online portal. The team is all a part of that discussion, and we can send out a request for service: 'So and so is complaining of this ailment'. We'll get a response quite quickly, or they provide other advice of, 'No, just get them to a hospital."** (External Provider)

Providers described how the secure messaging feature within the system enabled consistency in the care provided for clients, which was particularly important as they were often navigating numerous services within the community. For individuals facing numerous social vulnerabilities (e.g., financial barriers, discrimination), this consistency allowed for health and social needs of clients to be addressed:

> **"So, I saw one of our clients on Tuesday and it was like, 'That leg doesn't look good'. And I couldn't tell from what he was saying whether he had seen his nurse practitioner or not. So, I called her up and said, "Hey, are you following this?' She's like, 'I haven't seen it, can you take photos?" So, I did that."** (Internal Provider)

The use of group chats within the secure messaging system made providing care more efficient, allowing for the ability to text prescriptions or hold impromptu team meetings. Some service providers talked about the use of different channels on the secure messaging system for general program communication, as well as conversations about specific clients. For instance, providers spoke about having a channel for all members of the SSP and Specialized Outreach Services teams for broad updates and inquiries, such as investigating client's whereabouts if they had not been seen in a few days. One provider shared an experience of rapid case conferencing:

> **"This week I was at a very remote location, person is camping, they couldn't find this person [...] they had to see him for a few appointments, and I saw him. And there was this confidential space you can message in groups and I'm part of this person's care group. And if anybody sees this individual, 'Can you please?' There he is. I grab him and I say 'Hey, come on in let's make a phone call to [organization name]'. And we made a phone call you know and then all of a sudden, I was able to facilitate at his tent yesterday, a meeting between one of the nurses and [organization name] right there on the ground which is cool."** (External Provider)

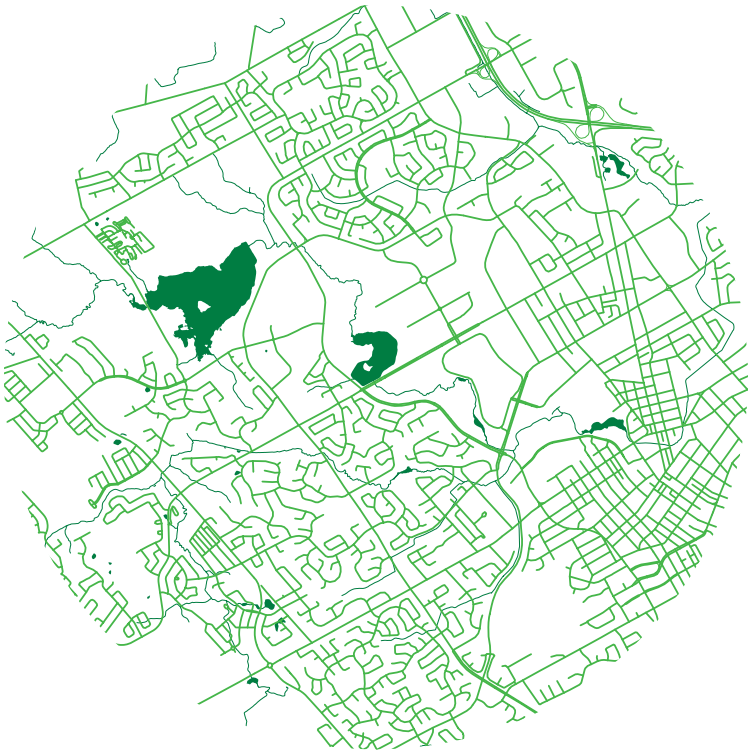
Providers are able to leverage relationships to deliver collaborative care

Providers told us that collaborative care was possible because of the established relationships between individual providers and partner agencies, and because across their careers they had worked at many of the partner agencies. Both factors contributed to shared knowledge of organizational services. About this, one provider remarked:

> **"It's a relationship-based kind of thing. A lot of the folks I work with, my coworkers, have worked for different organizations prior so they have a lot of those kinds of connections. As someone who is coming in not from a different organization, I find that I struggle because I'm still building those connections. So, when I first started, they had me head out with some of the different organizations to start building that, and that's been great. So, I've had some of the nurse practitioners over at the downtown community health centre, we started to build up really good relationships."** (Internal Provider)

Providers who had been engaged with the ICHA for longer periods of time described increased comfort in navigating the services offered. The knowledge, relationship building, and trust developed enhanced their ability to navigate and collaborate with various agencies:

> **"If I know [service provider] is seeing this person, I know that they're medically OK and I don't have to worry about that. I don't have to worry about saying, 'Look, please come to the bus tonight', you know, that kind of thing. Or if I know that [service provider] has seen them, I know all their case managers. That they've talked to their ODSP worker, that everything is set up, the cab rides are in the right spot, and I only have to worry about…I have like five or six questions I ask automatically. But this way I know I'm only asking one or two questions when I see them. That's the helpful thing to me because then it lets me focus and I don't have to worry about all of it."** (External Provider)



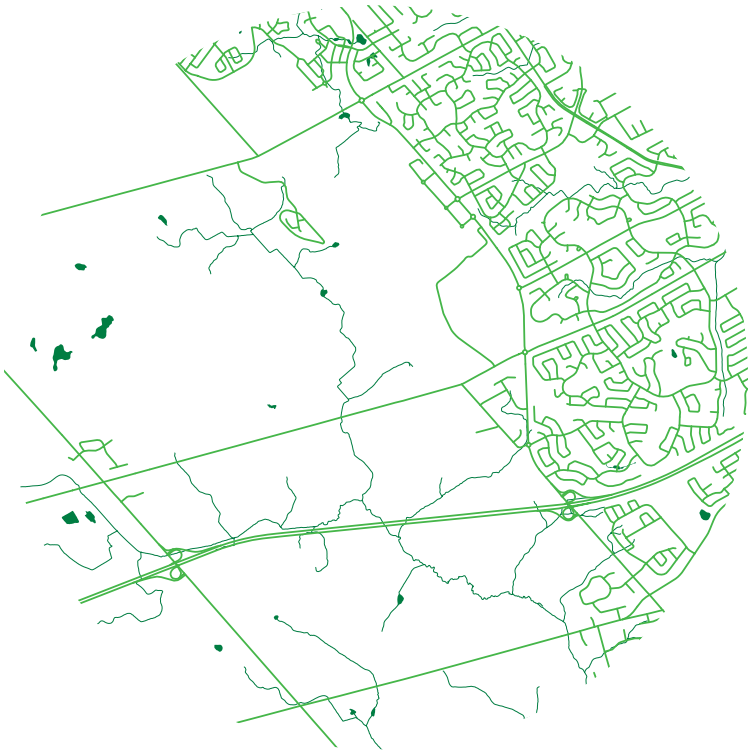
A Focus on Person-Centered Care

Providers highlighted that person-centred care involves surrounding clients with wrap-around services and building meaningful relationships:

> **"It also makes them feel like part of a team in that if I am at the campsite I was at yesterday and I ran into like three or four people who are on safe supply, they feel part of a team. They feel they can access more than one person for a point of care. As I make the introduction to a nurse that I'm working with, it's an easier transition. You don't have to lie about using drugs you know. Like we've been doing this long enough, harm reduction long enough that most people understand that, but safe supply is another little cog in that gets people to trust, right?"** (External Provider)

Given the collaborative care model, clients were able to access a variety of services, all which were aimed at improving their overall circumstances. Providers and clients collaborated on the services and opportunities that would work best for them. This offered clients a sense of stability and allowed them to reduce exposure to factors which promoted trauma:

> **"I think…it's safe supply in conjunction with access to safe and appropriate shelter is where we see the biggest impact in terms of overall wellbeing. I think when people have a safe place to stay and consistent access to medication, we see the level of risk go down, and we see changes in people's physical presentation. We see changes in terms of the types of calls for service we receive. Oftentimes, fewer crisis-type calls where people are in an acutely elevated situation or a high-risk situation, and I think we see a decrease in adverse health outcomes, a decrease in abscesses and engagement in high-risk activities."** (External Provider)



A focus on trauma- and violence-informed care

Embedded with the collaborative care model is a commitment to the practice of trauma- and violence-informed care. Service providers within the ICHA shared a deep understanding of the ongoing traumas faced by clients. They reflected on the many ways of attending to trauma when providing care: offering flexibility in service delivery, fostering choice and collaboration in decisions regarding client's health and social needs, and focusing on targeting elements of structural vulnerability for clients. As one provider noted:

"I think I try my best to be very trauma-informed with the way I have discussions and lead a conversation or lead a follow up appointment or intake, especially when it's my first time getting to know someone, or my first time ever meeting them or seeing them, I let them know that they don't have to tell me anything. They can take a break whenever they want. I don't have to take their vital signs, none of this is mandatory, none of this is meant to make them feel uncomfortable, that I understand that medical settings can be triggering. It causes a lot of anxiety, and we're not here to do that." (Internal Provider)

Flexible programming was reflected in appointment attendance options, service delivery options (e.g., outreach), program intake (e.g., external providers completing SSP intake procedures for clients), and in dosing schedules (e.g., flexibility around missed doses). Offering flexibility was driven by knowledge of the complexities faced by clients, and an understanding of how this often created barriers in engaging with health and social services for clients [17,18]. This allowed clients to engage with services in a manner which felt feasible and safe:

> **Right now, we're shifting again because I want to move more into community. People who are really struggling to come into clinics, just doing individualized care plans so that we can connect with them in community and do those follow ups there. And maybe significantly reduce the amount of time they need to come to clinic. If people are missing appointments - this is very new - just reaching out through our [communication] channel which is a confidential chat that we use. And just saying, 'These are the people who have missed. We haven't seen them in clinic for weeks, can we do community follow-ups and then let the prescriber know?' We try to be intentional about that, finding people that we're not just seeing in clinic. Yeah, and our team is in community a lot too. So, they generally have eyes on a lot of people just because we have the main hubs where people tend to gather."** (Internal Provider)

Internal providers and clients described having a collaborative relationship with one another which fostered agency and choice for clients. Clients described safer supply in sharp contrast to previous engagements in health, social services, and even other forms of addiction treatment (e.g., residential treatment or methadone programs), which were often described as perpetuating forms of trauma. Clients expressed that providers were often understanding and allowed them to determine their own care, including their safer supply medication doses:

> **To be honest, for me to get to where I don't feel like using, I would say 'I would increase probably the Dilaudid a few more'. I know that most people get the 8s, I asked for 4s because I don't like to play with drugs. She asked me why I wanted the 4s, right? Because typically I think they just give out the 8s. For me if I'm breaking pills in half then I'll start cutting them and snorting them. And right now, I'm doing really good. Opening the lid and eating a couple of tablets and then closing the lid on it right. So, she gave me 4s."** (Safer Supply Client)

Integration of medical and social services to provide wrap around care

The collaborative care model facilitated access to a wider range of services and supports than individual organizations could provide. Supporting clients in navigating care was described as crucial, regardless of which agency took on that role. Service providers discussed the importance of making social support available to clients and the benefit of integrating these services with medical care and safer supply:

> **"So healthcare is a service. Housing is a service. Safe supply is a service. But social supports, is kind of the client and the social support worker. At least this is how I envision it; the client and the social support person are kind of in the middle and they kind of hold all those pieces together."** (External Provider)

The different services were seen as complimentary; for example, social supports that assisted clients to get to appointments and pick up their prescriptions at the pharmacy enabled engagement in the SSP:

> **"But it's those social supports that seemed to be able to really support what I'm doing for this patient, right? Whether I'm making sure the pharmacy is delivering the medication. Or is it a test, or to see a specialist? That social support is huge, and it's really helped a number of patients, not just with the safe supply program. They're able to compliment other, other agencies and what they're doing."** (External Provider)

Integration of medical and social services allowed health care needs to be addressed in a more holistic and upstream way:

> **"Helping people deal with not just situations as they arise, but longstanding issues that haven't been addressed because of the instability of their living situation. Now for some of them who have been here almost, going on two years, they've reached a point where they're able to address things and have a team to continue with the follow up. It would be one thing for somebody to have an infection, go get a prescription, but then they lose the prescription, or it's stolen, or they just stop taking them. Whereas we have a team here, not just of healthcare professionals but of people who are following and walking alongside people here and saying, 'Oh hey, it's time for your night time med.' Or, whatever the situation is."** (External Provider)

Supporting clients who may be difficult to reach

The collaborative care model helped clients, particularly those who were described as hard to reach (particularly due to homelessness and the frequent displacements people experience due to this), stay connected to care. For example, one internal service provider explained:

> **"It helps clients who may have had a stronger relationship with another agency prior to even meeting us. It can help them to get to our safe supply appointments or other external appointments that they need to get to. I think having other NPs and supports doing primary care is helpful because holy man, like it would be super hard to address every single concern a client had. So that's also a huge benefit."** (Internal Provider)

Given the scope of the ICHA, clients were able to connect to care within various locations, improving accessibility and relationship continuity:

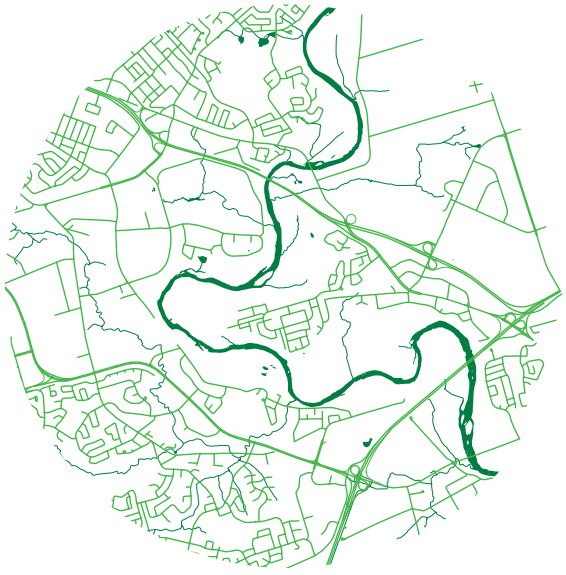
> **"One benefit is the accessibility because there's always somebody somewhere who can consult or see [the clients]. And even if you know they're connected to one NP, because of the relationships and the development across the teams, over time, it's the accessibility really."** (Internal Provider).

Challenges in the Collaborative Care Model

Clarifying the team of service providers most responsible for Safer Supply Program clients

Establishing the SSP required changes to existing collaboration and communication methods across different health and social agencies. Some providers identified tensions in determining who was most responsible for client care. This was explained to be particularly challenging during the initial transition to a collaborative care model, as providers figured out new roles, and who would be providing specific services. As one internal service provider explained:

> **"When the program did start there was a little bit of tension with some people in regard to like that's my client, my client, my client. As opposed to them just realizing the perks of full wrap around care."** (Internal Provider)



Sometimes, care teams were established on a case-by-case basis with SSP system navigators playing a key role in connecting individuals to needed services. Some SSP clients received help navigating the services available from the SSP whereas others received supports from the Specialized Outreach Service team. This was described as creating confusion for clients regarding who the central point of care was:

> **"I think sometimes, having a large team of supports who offer different things can be confusing to people who are receiving supports, and that can create some confusion and some complexity. I think…people who are supported by SOS [Specialized Outreach Services] have a pretty strong understanding that if they reach out to our team, we'll be as responsive as possible and try to address their presenting concern that they're experiencing in the moment. Whereas sometimes if people are connected specifically to the safer supply program, I think the mandate is a little bit more particular, so the level of responsivity looks different, and that can be confusing for people who are accessing services from both teams and can I think create a level of frustration or sometimes the more intensive wraparound or complex care pieces fall back to SOS."** (External Provider)

Challenges in negotiating coordination of medical care

The lack of clarity over the most responsible health care provider or team sometimes led to challenges coordinating medical care across the ICHA, due to confusion about who was responsible for providing particular types of medical care, following different medical conditions, and/or prescribing medications for other health conditions.

> **"I think we could definitely work on the collaborative piece with the MD and NPs. Because what sometimes is happening is you know like a patient of mine will go in and they'll treat an infection and it's often we don't hear about it right. Yeah, and that's happened actually a number of times. And we can definitely do better with that."** (External Provider)

While some of this confusion was related to a lack of clarity about the primary or most responsible healthcare provider, some providers expressed concerns about the lack of communication between healthcare providers (for example, regarding safer supply medication doses) and how that impacted their ability to deliver effective care:

> **"So, when that prescribing started for people, if there was shared clients, you know one NP is doing primary care and then all of the sudden this physician comes in starts prescribing opioids. And so, it just got off to a really bad start because NPs, again they don't know anything about it either. And so, you don't have somebody sharing with them why they're approaching it or prescribing or doing what they're doing. So, it created a lot of tension."** (Internal Provider)

While effective communication was highlighted as a key feature that enabled the collaborative care model within the ICHA, participants described instances where the lack of communication and/or a method to share information about patients (e.g., lack of a shared medical record) could introduce challenges in coordination of care or when referring clients to specialists:

> **"For me one of the challenges is not really knowing where people are at in their journey. So, if I make a referral to a specialist, I don't feel like I have the full picture on what doses they're on."** (External Provider)

Some of the communication challenges were linked to who did and did not have access to ConnectingOntario, a secure online system which provides access to some health records, including history of medications dispensed, hospital visits, and laboratory results [19]. Without access to ConnectingOntario, some nurse practitioners and nurses were unaware of the medications prescribed to patients by other healthcare providers, and worried this may interfere with care plans. This was exacerbated by the lack of a shared electronic medical record system.

Challenges with differing perspectives among organizations and providers

While many providers felt supported by the wide network of colleagues within the ICHA, not all clinicians in the Kitchener-Waterloo area were as supportive of safer supply and harm reduction. For example, one provider highlighted the difference in ideological approach between safer supply and addiction medicine services.

> **"There's all different kinds of perspectives on safe supply right. So maybe they're [addiction medicine physicians] not so happy that their client is even on safer supply period. And maybe now their [addiction medicine physician's] perception is health issues are because of safer supply. So, I think there's some tension that makes it difficult to keep the client at the centre when that's present."** (Internal Provider)

Another emphasized how the varying perceptions of safer supply impacted the full implementation of the program:

> **"The main challenges I find are just across the healthcare community and the perception of safe supply and the acceptance of it. Like, I find a challenge to really provide the best service when you're not able to collaborate on a level you know that you could for a client."** (Internal Provider)

Another provider elaborated on how different perspectives sometimes played out in the type and level of supports provided:

> **"It's challenging when people have access to a prescription from a particular provider and there may be different perspectives around supporting that person to attend their follow ups or to attend the pharmacy and the steps that are needed and the level of intensity of supports and services needed to be able to get the person to where they need to be. I think the level of intensity of service, or the type of wraparound service might look different between the two teams or number of visits that would be appropriate or practical within a week. I think there are different perspectives around level of risk and staffing in different situations as well, or the intensity of the service provided in order to ensure that the individual is able to access their needed follow up."** (External Provider)

Challenges referring clients to the Safer Supply Program and with the intake process

A major challenge discussed by providers regarding SSP service delivery was the intake process. Participants from across the ICHA village agreed that the intake process into the SSP was overwhelming and its length is not feasible for many people who use drugs. Several external providers voiced concerns with respect to the referral process and frequency of intake (which was monthly at the time of data collection):

> **"I will say it's extremely difficult to get on that program. Because what they do is once a month - and they've cancelled this past month - but you have to essentially be there at a ridiculous hour and you can potentially be in that line for 2, 3 hours. So, if I wanted one of my patients to get on the program, I would have to wait two or three hours in line to get them on. So then potentially there could be four or five social workers, nurse practitioners, nurses, outreach, sitting in that line. That's a lot of manpower."** (External Provider)

Internal providers also reflected on the difficulties of the current intake process. Many explained how emotionally and physically exhausting the process was for clients and suggested adapting the process to be more streamlined and efficient:

> **"I think our intake process could use some work. I think it's hard for people, but I don't really know what could be done to make it better. But it's hard for people because like they wait outside for hours on referral day, and of course it rains every referral day! So, people are waiting out in the rain for like 6 hours. And then, when I call them to say, 'Hey, you're going to do an intake appointment,' to them it is just a whole other thing that they have to wait for because they're not actually getting a prescription then, that takes another couple of weeks after that. Which is fair, we need to do our due diligence before providing anybody with a prescription. But it is hard, because it's hard to get people to that appointment and it doesn't even have the motivator of, 'Well if you come, you'll get your prescription!' And it also just a weird process because we're asking people to be so open and vulnerable with us, with no guarantee that they'll even make it into the program."** (Internal Provider)

Some service providers also highlighted that having a way to refer high priority clients experiencing severe medical situations would be useful:

> **"I think there needs to be some kind of prioritization tool. In terms of 'This person just had a life-threatening illness or was just in hospital.' Or this one is having multiple overdoses. You know there needs to be some kind of prioritization tool that goes beyond lining up, first come first serve."** (External Provider)

Clients overwhelmingly echoed the above challenges, expressing that they found the intake process to be inaccessible and overwhelming. For many, it took months of waiting to get onto the program, which increased their risk of overdose:

> **"Getting on the program was a challenge because they only accept 20 patients the first week of the month. And when I got on there was - the first 12 people in line were outreach workers handing in applications for their clients. But yet I stood out there in the cold in the winter. I had to wait about 6 weeks until I actually got on. Like got a dose and everything like that. But it's not fair to the people that have mobility issues, or you can't make it for some reason. I understand sending an agent in your place. But the first 12 people were all - even Sanguen employees handing in applications for people. I kind of thought that was wrong."** (Safer Supply Client)

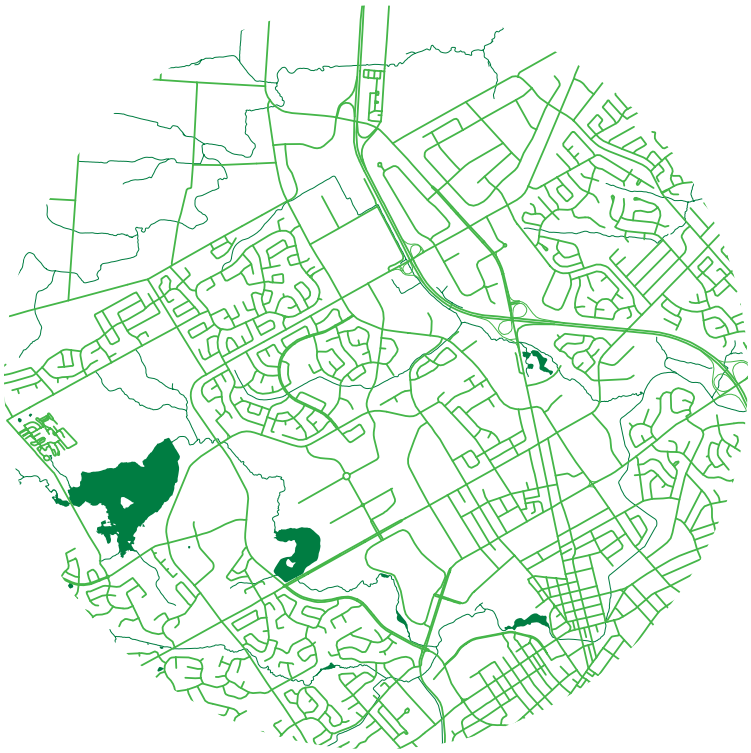
Confusion navigating the SSP for external providers and clients

While participants noted that the collaborative care model was enabled in part because of their knowledge of organizational services, those from organizations where safer supply was not prescribed noted that they did not fully understand how the SSP operated. This impeded their ability to support clients:

> **"I don't always understand how the [SSP] program functions. [Name] did say once you should shadow right? And I'd like to see how it goes for a day, what that looks like. Because that's something I do with other programs at other agencies sometimes. I say, 'Can I just come and hang out for a day, see what you guys do?' Because I can't make judgment calls about stuff until that happens."**
> (External Provider)

Clients of the SSP spoke about sometimes being confused and/or frustrated by the different supports available and differing levels of responsiveness across services. Similarly, external providers noted that clients had difficulty navigating medical care because they were unsure which physician/nurse practitioner provided what services and supports. Some service providers suggested that, given that the SSP was a new program and coordination of care was still being developed, improvements and streamlining of communication would advance the experience for clients and service providers:

> **"I mean the easier that we can make this for clients also it will become easier for us as health care providers right. The more that we can figure out how to work together, avoid redundancies, capture clients where they are at in the moment when we find them, that can only benefit the client in the long run and certainly make our lives easier. "**
> (External Provider)



Summary of Strengths Identified

Providers and clients both discussed the positive impacts the collaborative care model had on the accessibility, continuity, trust, and effectiveness of health and social care offered. Below we provide an overview of three main strengths identified about the model.

1) The collaborative care model is a unique service delivery method that improves accessibility of a diverse village of supports for people receiving safer supply

Participants shared how the collaborative care model enabled access to a diverse range of supports for clients of the SSP, which an individual organization could not provide. This model provided enhanced points of contact through a variety of different spaces within the service landscape (e.g., community health centres, shelters, harm reduction programming), improving accessibility and engagement in health and social services among clients. Clients discussed how the wrap-around nature of the SSP removed barriers to navigating multiple agencies without support, to meet all their health and social needs.

2) The collaborative care model enables providers to leverage relationships across a range of services to deliver person-centred and flexible care

Providers shared how the collaborative care model allowed them to lean on health and social providers within the community to better support the SSP clients. Established relationships and trust built across agencies allowed for person-centred and flexible care and support for clients, including locating clients, ensuring continuity of health treatments, and facilitating access to social services and housing.

3) The collaborative care model enables continual and appropriate access to primary care to people with complex health and social needs

Access to safe and continual primary care for people with complex health and social needs remains a challenge. Prior to engaging in the SSP, clients tried to address their health care needs through often inaccessible external services, emergency departments, or left them unmet. The strong focus on primary care across the collaborative care model ensured clients had their health needs addressed, regardless of what organization they were engaging with. This allowed for a continuity of care and improvement in overall health and health care access.

Summary of Areas for Growth and Development

Providers and clients shared a variety of recommendations for how to improve collaboration across the ICHA. These areas for growth and investment include aspects of focus on both programmatic and broader structural levels.

1. Improve safer supply program intake process

Unanimously, providers and clients reported that the intake process for the SSP needed to be more streamlined and accessible. Service providers recommended increasing the number of intake days, reducing reliance on a line-up model, and reducing the number of people clients had to see during intake. They also recommended integrating an referral system for external providers to refer clients directly. Some external providers suggested implementation of a "prioritization process" for clients with medically urgent needs.

2. Improve collaboration between internal and external providers

Providers shared a need for increased collaboration and coordination of care between service providers from the SSP and external agencies. External providers shared how they would like to be more involved in collaborative planning regarding client's care plans. Many suggested having more preventative based conversations or *"collaborative care planning"* meetings scheduled routinely between internal and external providers rather than treatment or *"crisis"* based conversations. These meetings should prioritize explanations of SSP processes and provide opportunities to clarify roles of team members.

3. Improve communication and coordination of care between internal and external providers

Internal and external providers described a particular need for communication around coordination of medical care, including identifying primary or most responsible healthcare providers for each client of the program. Internal providers shared that improving communication between varying members of the team (e.g., prescribers and social workers) would allow for a more comprehensive understanding of client's needs and supports required. It was also recommended that communication pathways become more formalized between agencies. One method to facilitate this is to ensure that all ICHA partners provide access for their medical care providers to ConnectingOntario. A shared electronic medical record system would also be useful.

4. Strengthen outreach services provided to increase client engagement

Internal and external providers highlighted that outreach was a crucial and vital part of reaching clients of the SSP, particularly those who were homeless and living in encampments. Outreach services can be all encompassing and include medical, social, and support related to safer supply prescriptions; strengthening these services was felt by participants to be crucial in ongoing accessibility and engagement for clients. Beyond this, the integration of more outreach-based services within the SSP would improve access and availability of health and social care to groups who face unique challenges engaging with institutional spaces due to histories of trauma and harm.

5. Increase support for internal safer supply program staff

Internal providers of the SSP voiced the need for more formalized staff support structures. Providers shared a desire to have a more structured system in place where they could go to: 1) debrief on issues they are navigating with clients; 2) learn more about program level decisions; 3) engage in mentorship from senior staff and leadership team members; and 4) have an opportunity to provide feedback about the SSP.

Methods Appendix

As part of its SUAP reporting obligations, the SSP program leadership team commissioned an evaluation of the Kitchener-Waterloo SSP that focused on implementation successes, challenges, and opportunities for improvement from the perspectives of clients, and both internal and external service providers. This report is the second of two reports that presents findings from a preliminary evaluation of the program. The first report focused on the Impacts of the Safer Supply Program [5], while this report focuses on the Collaborative Model of Care that guides service delivery.

This report draws from interview data collected from clients and internal and external services providers working with the SSP.

Qualitative Interviews: To gather rich data on the program operations, implementation and scale-up, qualitative interviews with key informants were used in this evaluation. Interviews were conducted with two groups: 22 SSP clients and 22 service providers from the program. Service providers comprised two groups: internal service providers who were Sanguen Health Centre staff members (referred to as internal service providers in this report), and external service providers who were staff members employed by partner organizations who worked in collaboration with the SSP, but provision of SSP was not their direct role (referred to as external service providers in this report). Interview questions focused on core processes of the SSP (e.g., enrollment and referral protocols), program outcomes, and strengths, limitations, and recommendations for program improvement. Participants were also asked to complete a short demographic survey. Both internal and external service providers were sent an email with information on the evaluation and asked to contact the team directly to schedule an interview if they were interested in participating. For clients, notices about the project were posted at the SSP sites, and interested clients were also invited to participate in interviews on days when the interviewers were onsite.

Data collection for qualitative interviews occurred in the summer 2022, with semi-structured interviews conducted with 22 clients of the SSP and 22 internal and external service providers including physician, nurses, care facilitators, nurse practitioners, systems navigators, outreach workers, social workers and people in management positions. Interviews with clients were conducted in-person, while most of the interviews with internal and external providers were conducted by phone or virtual platform (Zoom). Interviews were conducted by MP, CS, GK, and AG. Interviews lasted between 20 and 90 minutes, were audio-recorded, and stored on an encrypted drive. Qualitative data were managed using NVivo and demographic data using Qualtrics and Excel. Thematic analysis was conducted to identify and analyze themes and patterns in the data. The coding framework was developed iteratively starting with the evaluation objectives and refined during the analytic process.

Who we spoke with

Twenty-two service providers were interviewed for this evaluation, including 13 care providers who worked for the Sanguen Health Center (referred to as internal providers) and 9 care providers who worked for agencies under ICHA and collaborated with, but did not directly deliver, the SSP as part of their role (referred to as external providers).

Provider roles range from physicians, nurses, care facilitators, nurse practitioners, systems navigators, outreach workers, social workers, and people in management positions. All providers identified as white. Additionally, 73% of service providers identified as cis women, 22% of service providers identified as cis men and 5% of service providers identified as gender diverse.

We also spoke with 22 clients of the SSP. 55% of clients identified as cis men and 45% of clients identified as cis women. In terms of race or ethnic identity, 91% of clients identified as White and 9% of clients interviewed identified as Black, Indigenous or other racialized groups.

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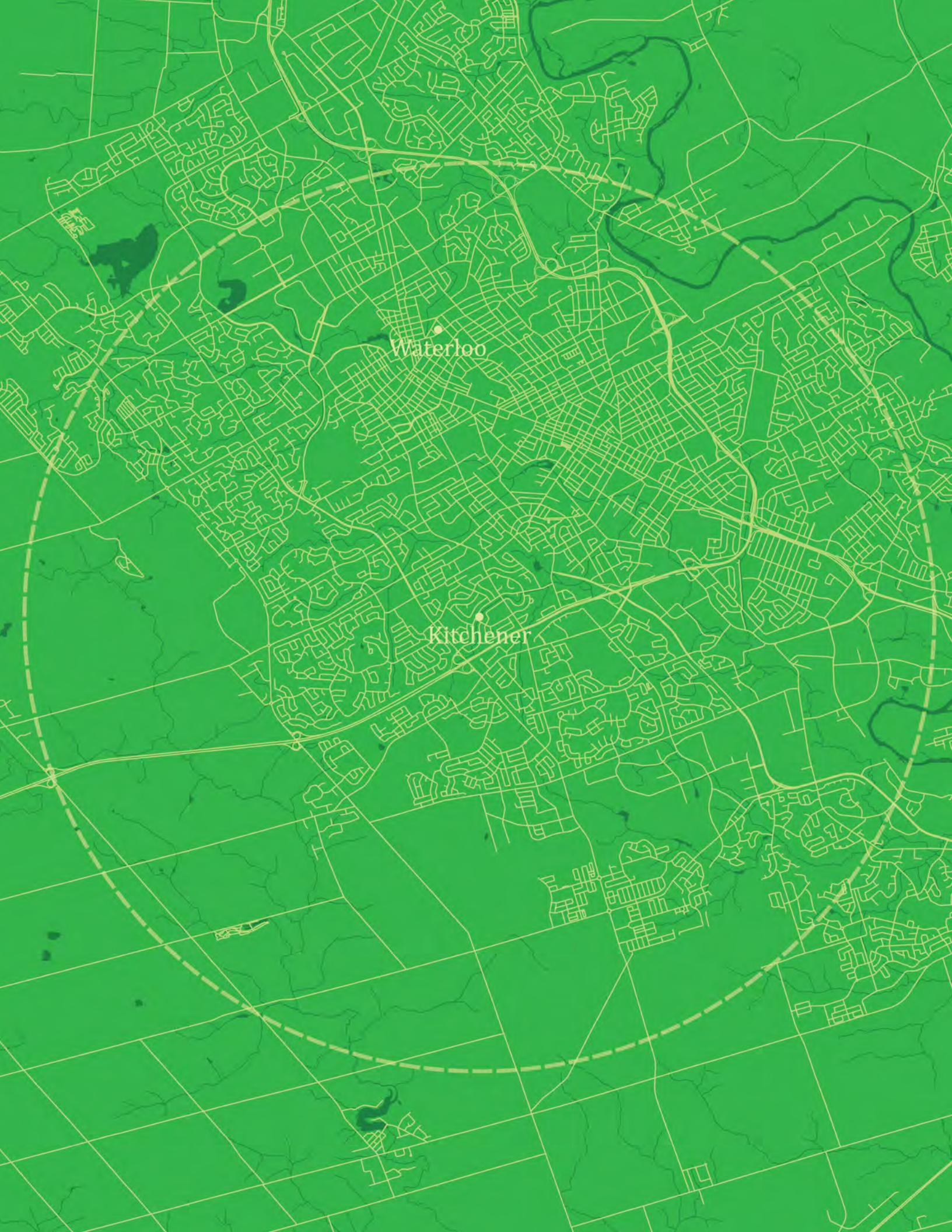
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