Summary Report for The Kitchener-Waterloo

Safer Supply Program

A Collaborative Model of Care • September 2023

Background

Over 32,600 deaths due to opioid toxicity have been recorded in Canada between January 2016 and June 2022. The onset of COVID-19 in March 2020 exacerbated the impacts of the unregulated and highly toxic drug supply on overdose rates across the country. Safer supply programs – where pharmaceutical medications are prescribed to people to reduce their reliance on the unregulated drug supply – are one intervention aimed at mitigating impacts related to the increasingly potent unregulated market of fentanyl, fentanyl analogues, and benzodiazepines. In Kitchener-Waterloo, the Inner-City Health Alliance (ICHA) received funding in 2021 from Health Canada's Substance Use and Addiction Program (SUAP) for the implementation of a Safer Supply Program (SSP). Since then, the SSP has been delivered as a wrap-around health care and harm reduction service within the ICHA using a collaborative care model.

A variety of different program models are currently being used for safer supply delivery across Canada. Models include the delivery of safer supply through community health centres, in supportive housing settings, in addiction medicine practices, using biometric dispensing machines, as well as prescribing that occurred using risk mitigation guidelines to facilitate COVID-related isolation in the pandemic period. 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.

This summary report outlines the findings from the report: ***The Kitchener-Waterloo Safer Supply Program: A Collaborative Model of Care.*** It is part of an evaluation of the Kitchener-Waterloo SSP, drawn from interviews with clients, internal service providers (staff of Sanguen Health Centre who directly provide safer supply programming), and external service providers (staff members from partner organizations who work in collaboration with the SSP). It summarizes how the model operates, elements of the collaborative model that are working well, challenges in the model, a summary of strengths identified in the evaluation, as well as areas for growth and investment.

Collaborative Model: An Overview

The collaborative care model used in the SSP in Kitchener-Waterloo stems from the ICHA's network of health and social service providers, who aim to provide holistic and person-centred health and social services to people living in vulnerable conditions, specifically individuals experiencing homelessness, housing insecurity, and refugees in the Kitchener-Waterloo area of Ontario. The ICHA is made of up of six core community agencies that aim to provide coordinated and integrated health and social services.

Service providers expressed a shared purpose, which includes a unique service delivery model that helps clients access diverse services at varying times across the village of supports available within the ICHA to help clients meet their individual needs. There was a common recognition that for vulnerable clients experiencing high levels of both medical and social complexity, participation of multiple organizations across the ICHA was necessary to properly provide the medical care and social support necessary for clients.

Elements of Model which are Working well

Secure messaging system enables communication across agencies

The ability to confidentially share health information in a secure way facilitated efficient and consistent care among clients who were navigating numerous health and social services to addressing different needs. Providers across the ICHA described the importance of using a secure, encrypted, and Personal Health Information Protection Act (PHIPPA) approved platform, which enabled individuals from different agencies to collaborate on SSP client care by messaging each other, sharing clinically relevant pictures, texting prescriptions, and even holding impromptu team meetings.

> **"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 are able to leverage relationships to deliver collaborative care

Existing relationships between agencies and individuals facilitated collaborative care, and providers who had been engaged with the ICHA for longer periods of time described increased comfort in navigating the abundant services offered.

> **"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."** (Internal Provider)

A Focus on Person-Centered Care

The importance of person-centred care echoed across conversations with all service providers. Regardless of challenges faced working across the ICHA model of care, many providers emphasized that client interests were always prioritized. Providers highlighted that person-centred care involves surrounding clients with wrap-around services, providing trauma-informed care and conversations, and building meaningful relationships with clients.

> **"Someone might come in and not want to address mental health or not think that's the priority. Even if my assessment is different, I think it depends on what they're ready to engage in. Sometimes, I find if it's an acute physical health need, that usually comes first for folks. If someone has an upcoming surgery, or is in and out of hospital, or has a significant infection, those things take precedence. You build trust, once you're done following up with that medical need, then people start to contemplate counselling or other kinds of support options, and I think that comes with a prescription, too. Support needs change as the prescription changes."** (Internal Provider)

A focus on trauma- and violence-informed care

An important component of the collaborative care model offered across the ICHA is the uptake of trauma- and violence-informed care. Providers reflected on the many ways in which they considered trauma when providing care by 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. These factors allowed clients to engage with services in a manner which felt feasible and safe.

> **"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)

Integration of medical and social services to provide wrap around care

Support for clients navigating care was described as crucial, regardless of which agency took on that role. Service providers discussed appreciation for the social support available to clients and the benefit of integrating these services with medical care. The collaborative care model facilitated access to a wider range of services and supports than individual organizations could provide. Several providers noted that the collaborative relationships they built with each other led to more accessible and better care.

> **"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)

Supporting clients who may be difficult to reach

The collaborative care model provided an important advantage in helping service providers stay connected to their clients. Providers expressed that the collaborative approach to care increased accessibility for clients who are often 'hard to reach'. Given the scope of the ICHA, clients were able to connect to care within various spaces.

> **"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: Some providers identified tensions between individual providers due to challenges in sharing client care. Particularly during the initial transition to a collaborative care model, it was sometimes challenging for service providers as they figured out new roles, and who would be providing services within specific roles.

Challenges in negotiating coordination of medical care: Challenges with coordination of care between medical providers of the SSP and external agencies were identified by some service providers. Many of these challenges related to confusion about who was providing types of medical care, following medical conditions, or prescribing certain medications. Some of the challenges surrounding communication seemed to be due to a broader issue of lack of access to ConnectingOntario for some medical providers external to the SSP.

Challenges with differing perspectives among organizations and providers: While many felt supported by the wide network of colleagues within the ICHA, not all clinicians in the area were as supportive of safer supply and harm reduction. Some providers highlighted the difference in ideological approaches between safer supply and addiction medicine services.

Challenges referring clients to the safer supply program and with the intake process: Both internal and external service providers agreed that the intake process into the SSP was overwhelming and difficult for many community members. Clients also expressed that they found the intake process to be challenging.

Confusion navigating the safer supply program for external providers and clients: Several instances were shared in which clients were confused and/or frustrated by the different supports available and varying levels of responsiveness across services. Similarly, external providers signaled that given the varying medical providers which exist across the ICHA, clients sometimes had difficulty navigating services, partly due to a confusion among clients regarding which medical providers were able to provide medical services and supports.

Summary of Strengths Identified

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 accessibility to a diverse range of supports for clients of the SSP, which an individual organization could not provide. 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 for person-centred and flexible collaboration surrounding the provision of care and support for clients, including locating clients, ensuring continuity of health treatments, or enabling access to social services such as housing.

3) **The collaborative care model enables continual and appropriate access to primary care to people with complex health and social needs:** The strong focus on primary care across the collaborative model of supports 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 Investment

1) **Improve safer supply program intake process:** Unanimously, providers and clients felt 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, reducing the number of people clients had to see during intake, and integrating an internal referral and prioritization system for external providers to refer clients directly.

2) **Improved 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.

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) using formalized processes would allow for a more comprehensive understanding of client's needs and supports required.

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. 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 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.

This summary report provides an overview of findings from:

Perri, M., Fajber, K., Guta, A., Strike, C., Kolla, G. (2023). *The Kitchener-Waterloo Safer Supply Program: A Collaborative Model of Care. Report 2. September* 2023.