Overdose Outreach Team Storyboard Dec 2017

Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative

Overdose Outreach Team

- OOT is comprised of 3 ORWs and 2 SWs, plus administrative and leadership support.

- OOT was created as a stand alone team when Mobile Medical Unit (MMU) closed down in April 2017. ORWs were originally part of the MMU at 58 W Hastings to provide client follow-up.

- OOT provides connections to addictions care and support for clients in the VCH region who have recently experienced opioid overdose, and/or are at high risk for opioid overdose.

- Services Include:
  - Navigation to appropriate services
  - Support in accessing Opioid Agonist Therapy (OAT) (e.g., methadone, suboxone etc.)
  - Overdose prevention education

Aim Statement

- OOT aims to increase access to substance use and other relevant health and community services and resources by:
  - Ensuring that 95% of active referrals are contacted (phone, email, text, in person) within 3 business days. Target for 95% by January 2018.
  - Ensuring that 95% of active referrals are successfully linked to substance use or other relevant health or community resources. Target for 95% by March 2018.
  - Promoting information and resource sharing across the continuum of care by building new relationships with two new sites each month who serve clients at high risk for overdose. For example, ED, detoxes, supervised consumption sites, and overdose prevention sites. Target date by January 2018.

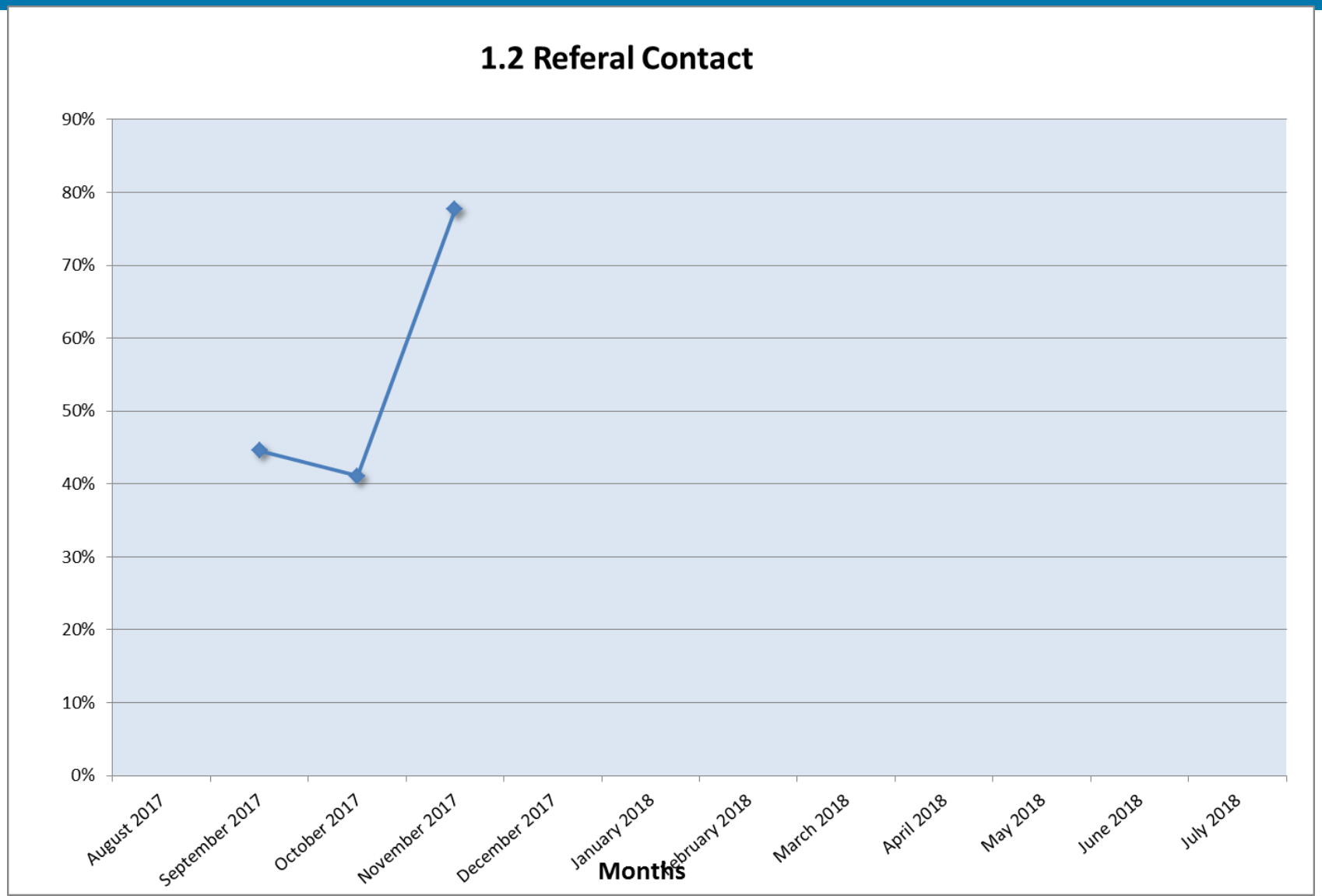
Population of Focus

- POF = 85. OOT's active caseload for November
- People who live within VCH region (North Vancouver, Vancouver, Richmond) who have experienced an overdose or are at risk of an overdose and would like support navigating substance use services.

Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative

Run Chart

Ensuring that 95% of active referrals are contacted (phone, email, text, in person) within 3 business days. Target for 95% by January 2018.



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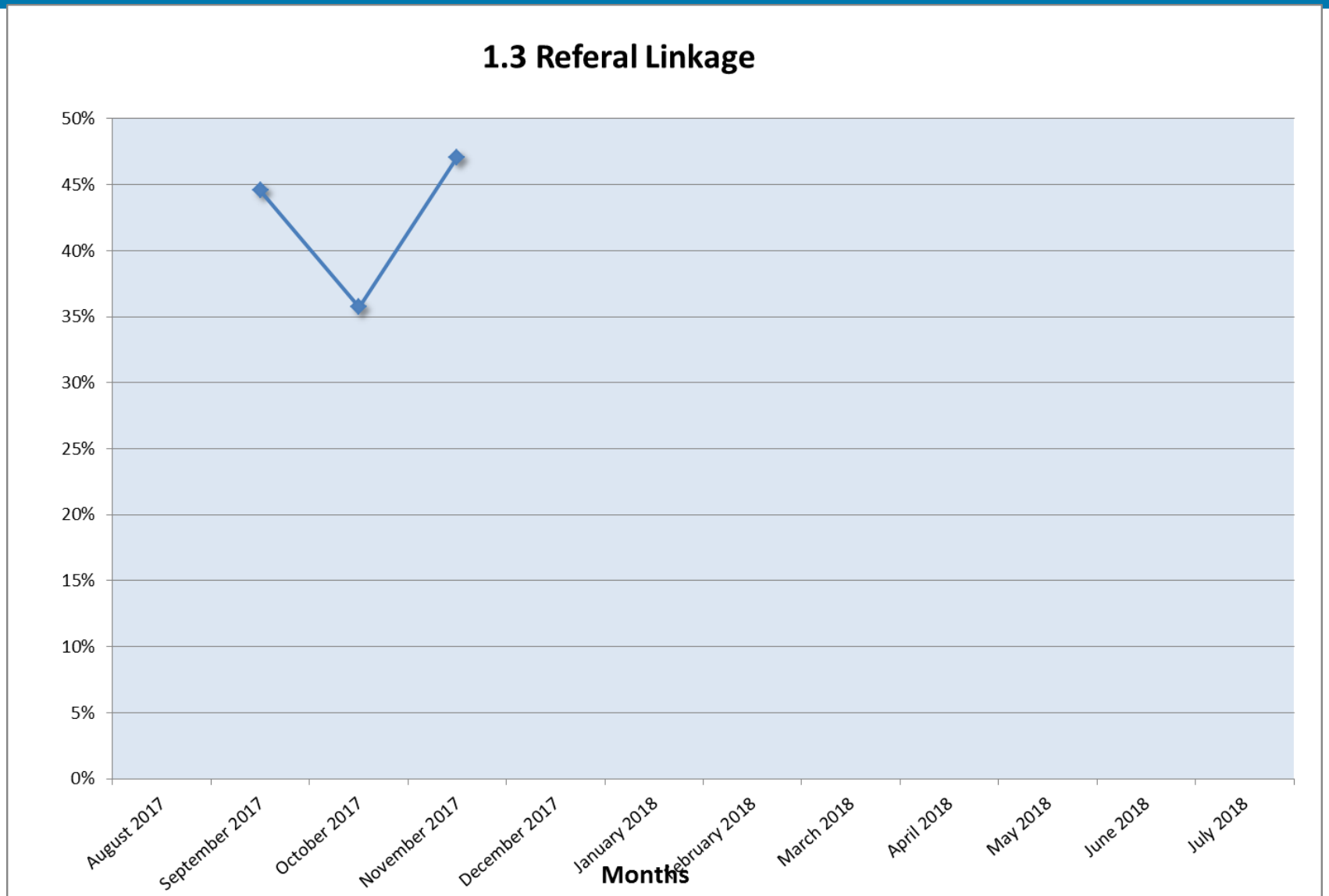
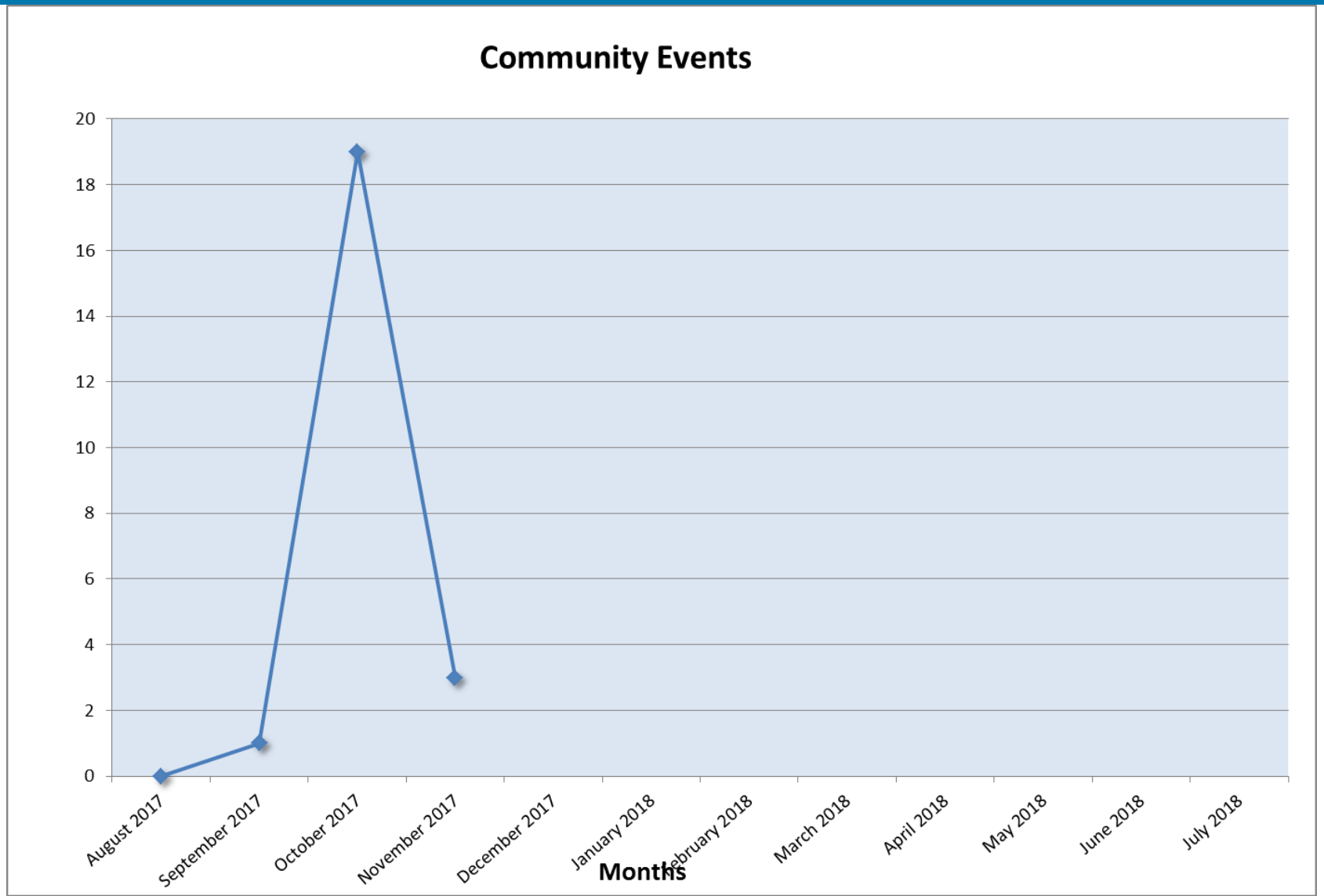


Run Chart

Building new relationships with two new sites each month who serve clients at high risk for overdose. *Aim statement changed in November.



Changes Tested Narrative Report

Establish SPH ED referral pathway

- Met with ED and RAAC leadership
- Created referral form tailored to ED needs during business hours (RN/LPN team)
- Created referral pathway for after hours
- NEW: MHO directive to ED physicians to refer all clients to OOT who have presented with OD
- OOT attending ED/RAAC drop-in hours
- Relationship built with RN Addictions lead in ED/RAAC
- **Total number of ED referrals from October 1st to November 22nd: 124**

Changes Tested
Narrative Report

Establish Insite referral pathway

- Met with Insite staff to learn what would be most helpful for their site
- Determined that drop-in hours allow Insite clients to choose whether or not they wanted to connect with OOT
- Four weekly drop-in sessions, ~3 referrals each session
- Through Insite OOT has connected with Onsite

Lessons Learned

- Building relationships with service providers is key
- Acknowledging the work that community is doing (peers, service providers, community members)
- Create a low barrier referral pathway
- Ability to connect the same day with clients
- Bridging between acute care and community

Looking forward…

- Regular drop-in hours with the same OOT staff to help strengthen relationships with community partner sites
- Shelter referral pathway
- In-patient addiction teams referral pathway
- Client survey
- Focusing in on people who are not connected to care anywhere

Contact Information

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