Addiction Recovery & Community Health

Implementation manual

Contributors

Ginetta Salvalaggio
Arlanna Pugh
Guillermina Noël
Saul Sych
Kathryn Dong
Curt Johnston
Corinne Sawarin
Rob Gurney

Acknowledgments

The following people provided extensive input on the manual's content and format

ARCH team members and leaders:
Karine Meador, Jennifer Brouwer, Esther Leung, Robert Terry, Janice Pyne

Knowledge Translation working group members: Stacy Lockerbie, Lara Nixon, Judith Krajnak, Kelly Mrklas, Elaine Hyshka

Community liaison: Shanell Twan

Plain language writer: Karen Schriver

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Our story

Before we started ARCH, we would see patients like Jack who had pneumonia but also a severe substance use problem. We would treat his pneumonia, but get frustrated when Jack went into withdrawal, used drugs in the hospital or left hospital before he finished his treatment and then came back sicker needing even more help. We were very good at treating his acute infection. But by not optimizing the management of his substance use disorder, we put him at risk and created a challenging work environment for us. **We needed to change the way we cared for patients at risk.**

ARCH got its start in 2014. That year we took a hard look at how we provided care to Royal Alexandra Hospital patients. Was the care equitable? Was it consistent with medical best practices? Were we striving for the maximal impact on health? Was it patient-centered? We were especially concerned with people experiencing poverty, homelessness, or those who had alcohol or other substance use problems.

To better meet patients' needs, we brought together a multidisciplinary team of healthcare providers. Our challenge? To combine traditional medical approaches with best practices in addiction medicine and the social determinants of health. We saw **the hospital stay as an opportunity to help people live their vision of a healthier life.**

We believe in relationship building and tailor care to each patient's needs and priorities. If Jack is in a lot of pain, we take care of it—so that he can feel safe and stay in the hospital. **We help patients engage in care.** If Anna is discharged from the hospital, we help her find housing and a legal source of income. If Sue's goal is to stop drinking alcohol, we show that we really want her to feel better, that her life matters. If Mike continues to use injection drugs, we help him to minimize the risks by providing sterile injection equipment and an overdose response kit (i.e., naloxone).

We don't judge, we respect. If John wants to start taking methadone so he can stop injecting opioids, we start it that day. If Mary is in the hospital with a broken arm and needs to see a surgeon, **we connect** her with the ID program so that she can get a photo ID, an Alberta Health Care card, and attend her appointment. If Tania is at risk for cervical cancer, but hasn't had a PAP smear in ten years, we offer it to her while she's in hospital for treatment of her heart infection. If Rick is at risk for having Hepatitis C but hasn't had a chance to get screened, we do it while he's in the Emergency Department (ED) after being resuscitated from an overdose.

At our hospital, we take care of patients whenever and wherever they show up. Our goal is that no one leaves our hospital without access to evidence-informed treatment for their substance use disorder. We also let people choose from a whole range of health interventions, even when they come in for only one thing.

Now, we are dealing with an opioid crisis, with an even greater demand for services. With fentanyl and other novel synthetic drugs on our streets, many more patients are showing up to hospitals and EDs needing help. **The time to change our approach to managing substance use disorders in acute care is now.**

With this manual we want to tell you our story—what we did and how we did it. We invite you to adopt our unique approach, provide relationship-based care for patients at risk, and save lives.

Approach: Compassionate wraparound support

Admission to hospital can be a traumatic experience for anyone. Coping with an acute or chronic illness—along with a myriad of health professions—can leave a patient feeling vulnerable, alone and afraid. People who come in with **an alcohol or other substance use disorder can be easily misunderstood. Far too often we perceive it as a "choice" a person has made, or somehow, a lack of willpower or character.**

As a result, patients living with these conditions often feel marginalized or blamed for their medical problems—they feel judged, especially when hospital staff act like they don't deserve the care they are receiving. At our hospital, we have come to understand that problematic substance use is the result of a number of factors, most of them out of the patient's control. The ARCH team offers compassion and caring to these at-risk patients. Three principles guide our approach:

- Provide evidence-informed healthcare, especially **addiction medicine** and the **social determinants of health**
- Focus on **harm reduction,** personalizing treatment for the right patient at the right time
- Provide **wraparound support,** meeting patients where they are, whether in hospital or in the community

Addiction medicine means the assessment and management of substance use disorders (tobacco, alcohol, and other drugs) and its complications, across a continuum of severity and patient preferences.

Social determinants of health means the multiple environmental and societal factors: income, housing, ethnicity, etc., that can impact human health and illness.

ARCH: Our philosophy of care

- Ignoring or condemning people with substance use disorders is counterproductive: a kind of closed-door policy
- Meeting people "where they are"—whether they need support with safer use, managed use, or abstinence is crucial: our open-door policy
- Exploring each patient's social and cultural context of use, along with their use itself, helps us see the whole person
- Building relationships with patients in hospital and the community fosters meaningful connections and personalizes harm reduction
- Providing supports that empower patients to take better charge of reducing the harmful effects of their substance use disorders can save lives

Corinne's story

"As an addiction counsellor with the ARCH team, I am honored to work with such a highly skilled and patient-centered interdisciplinary team. **The most important part of my role is to establish trust and build rapport with patients. My aim is to demonstrate genuine compassion and empathy, along with a non-judgmental attitude.**

By doing so, I am better able to establish a therapeutic alliance with my patients—allowing them to feel more comfortable sharing their story. This collaborative approach often empowers patients to discover solutions for themselves. It also helps patients avoid the feeling of being pushed towards a treatment path that is not of their choosing.

In the past, addiction treatment was largely abstinence-based. I've noticed a striking shift towards approaches based on the principles of harm reduction. Certainly, I still use relapse-prevention practices, but more often, I strive for **discussions and education rooted in the practices of harm reduction.**

These conversations take many forms. The patient may continue to consume alcohol daily, but want to stop non-beverage alcohol use. So we explore consuming a product with a lower alcohol content. Maybe they want to reduce the total number of drinks in a day, or they want information on a managed alcohol program.

Practicing harm reduction is also about distributing supplies and education about how to use them. We give out clean syringes, sterile water, filters, and teach safer injection practices. We offer patients a naloxone kit and show them how to use it. Sometimes we focus on supporting the patient to reduce the number of times they inject, for example, by switching to oral or nasal use. Other times it may be helping the patient access nicotine replacement. **Each of these interactions is an important opportunity to connect with a patient, possibly laying the groundwork for other changes.**

When I think of my role, the ARCH team, and harm reduction, **a specific patient often comes to mind.** A long-term IV opioid user, he had experienced numerous hospital admissions over the years. He was homeless, had little in the way of family support, and despite a tough exterior, was afraid he would not leave the hospital this time. Despite being very ill, he was also clear from the start that he was not interested in talking about his use. In his words, he was an "addict" and that would never change.

It took time. It took offering him harm reduction supplies and having him accept them. He started asking questions about safer injecting. He accepted a naloxone kit. When he had a conflict, he shared his feelings and asked for my help. Gradually, he began to share his story with me.

The shift was subtle, until one day he wanted to discuss starting methadone. He agreed to meet with the ARCH physician, who answered every question, addressed every concern, and built a level of trust with the patient he had never experienced before.

From there, **each team member stepped in to help.** He worked with our **peer support worker** to replace his ID and accepted his emotional support. Our **social worker** collaborated with the unit social worker to ensure he would continue to get his income-support benefits and assisted him in locating suitable housing. Our nurse practitioner advocated for him, both within the hospital and with community partners. She helped him connect to a **new family doctor** and offered education around harm reduction.

Each team member used their unique skills to ensure this patient left the hospital with everything he needed, and with a renewed sense of hope.

Shortly before he left the hospital, he shared with me experiences from past admissions—experiences he had before the ARCH team launched their program. He talked about how different this admission had been. **He said he felt cared for and valued. He knew the team saw him as a person, not as a problem. That respect helped him see his own worth.**

He told me he didn't see himself as an "addict" anymore and would not allow himself or anyone else define him in those terms again. I've held onto his words. They remind me of the importance of harm reduction, of patient-centered care, and of the significant impact the ARCH team is making on the patient experience."

Corinne Sawarin, RSW
Addictions Counsellor

ARCH Case Studies

Pam

She is 25 years old and 25 weeks pregnant. She presents to the assessment unit after an assault. She shows signs of opioid withdrawal. Two other children are not in her care. No contraception, no prenatal visits. She injects opioids daily but has been trying to cut down since her pregnancy. Pam smokes about 10 cigarettes a day and uses methamphetamines (smoked or IV) when she can't buy opioids. She's been part of the sex trade for a long time. She's homeless and without a legal income. She has no ID or Alberta Health Care (AHC) card to confirm her eligibility for health services. Because she sustained injuries from the assault, she is admitted for a brief stabilization period.

Opioid agonist treatment means the provision of medication designed to replace and block the effect of other opioids, thereby preventing withdrawal and reducing overall use.

ARCH care goals

- Engage into care
- Start opioid agonist treatment (OAT) immediately (see definition below)
- Investigate income supports (including medication coverage)
- Get ID / AHC card
- Connect to primary and prenatal care
- Link to community-based OAT program and counselling
- Provide an overdose response kit
- Order sexually transmitted and blood borne infection (STBBI) screening
- Suggest addiction counselling
- Offer peer support
- Offer harm reduction supports (e.g., condoms, injection supplies)
- Connect with community supports (sexual assault counseling, harm reduction)
- Inform about smoking cessation or nicotine replacement
- Advocate for Pam with the rest of the hospital care team

Richard

He is 27 years old and came to the ED after a near fatal fentanyl overdose. This is the third time in six months he nearly died from an overdose. Richard was unable to connect to opioid agonist treatment (OAT) in the community. He was previously diagnosed with depression linked to multiple adverse childhood events. He was staying at shelters, with no legal income. He also had no ID / AHC card and no medication coverage. He was stable on methadone prior to moving to Alberta. We treated him as an outpatient.

ARCH care goals

- Initiate OAT Immediately
- Identify income supports, medication coverage (emergency medication coverage through ED)
- Get ID / AHC card
- Order STBBI screening
- Provide an overdose response kit
- Refer to primary care / OAT program
- Provide harm reduction supplies
- Refer to ARCH clinic until he stabilizes
- Refer to counselling
- Give advice on other locations for harm reduction supplies

Raven

She is 45 years old and Indigenous. She has over 100 ED visits for alcohol intoxication. This time she was admitted to hospital with aspiration pneumonia. Raven drinks non-beverage alcohol when she can't buy regular alcohol, but consumes no other drugs. Occasionally she stays at a shelter, but mostly in a tent by the river. She had been on income support, but cheques stopped coming three months ago. She had no ID / AHC card. She has Non-Insured Health Benefits (NIHB) medication coverage through her band, but no primary care. She also has untreated diabetes and hypertension.

ARCH care goals

- Help patient complete medical treatment without leaving against medical advice—either by excellent withdrawal management or a managed alcohol program
- Refer for primary care
- Locate transitional housing
- Check possible income support from provincial disability support program: i.e., Assured Income for the Severely Handicapped (AISH)
- Get ID / AHC card
- Order STBBI screening
- Ask if she would like to see an Indigenous cultural helper
- Find a TV/DVD player or other distraction to encourage staying in hospital (part of peer support role)

Jeff

He is 45 years old with a long substance use history—including daily alcohol use, daily IV methamphetamine use, and weekly IV opioid use. Jeff was previously treated for left knee septic arthritis. He is now admitted with a stab wound to the left chest. He is Hepatitis C positive, HIV positive, and not on treatment. He has experienced multiple incarcerations and no permanent housing for the past 20 years. Jeff's only income is from the drug trade. He has no ID / AHC card and no medication coverage. He continues to use drugs in hospital. Jeff was found unresponsive in his hospital bed, likely from an unintended opioid overdose when his pain was not well managed.

ARCH care goals

- Provide appropriate and safe pain management in the setting of active substance use disorder
- Offer harm reduction (syringe exchange, supervised consumption, standing naloxone order)
- Give overdose response kit; put naloxone order on chart
- Check income support and medication coverage
- Get ID / AHC card
- Order STBBI screen and refer to treatment for HIV, Hepatitis C
- Schedule immunization screening
- Investigate housing options
- Offer a peer support worker for rapport
- Refer to primary care (as part of discharge planning)

Wraparound support

Providing **evidence-informed addiction medicine and harm reduction supports are necessary, but not sufficient.** We also need to be contextually aware, identifying appropriate wraparound supports that address the **social determinants of health.**

The supports that someone **needs will vary.** For one patient, it means help with getting income support, arranging for a valid ID, or applying for housing. For another patient, it means testing for STBBIs, arranging for a needed vaccination, and performing an overdue Pap smear. For someone else, it means setting up an appointment with a new family physician and making sure they get there—going with the patient to the appointment when necessary. **We work with patients to tailor supports to their needs and preferences, focusing on providing the right care at the right time.**

Our team is directly involved in many of these activities, but **we also work closely with other teams to address unmet needs for care.** Within the hospital, we connect regularly with unit social workers about mutual patients. We refer patients to Indigenous cultural helpers or the psychiatry service when a patient needs their specialized support.

We have also formed partnerships with a number of external organizations, including the Boyle McCauley Health Centre (to set up primary care for unattached patients); the Alternative to Warrant Apprehension Project (to address outstanding warrants); the Indigenous Wellness Clinic (to set up primary care and cultural supports); the Alberta Health Services ID Program (formerly known as the ID for the Homeless Healthcare Project); and Alberta Community and Social Services (to help with case coordination for various different programs, including formal Housing First intake, within the hospital setting).

Goals: Building relationships with patients at risk

The **ARCH** team listens to our inner city community to help understand when and why people come to the hospital so we can address unmet needs for care. We find that at-risk patients often experience **unstable housing/income, active alcohol and/or substance use,** and frequently both.

To meet the unique demands of these patients, we make our wraparound supports available within the hospital setting. ARCH's **multidisciplinary team of clinicians** provide inpatient and outpatient consultations. We follow our inpatients and offer outpatient Transitional Clinic follow-up (upon referral from RAH inpatient units or the RAH ED).

When ARCH launched its services in July 2014, our clinical team consisted of a group of physicians with **addiction expertise** (weekly rotation, extended hours), a full-time nurse practitioner (weekdays), and a full-time social worker (weekdays). Several months later we found there was an even greater need for our services and expanded our team. ARCH welcomed an addiction counsellor in mid-2015, followed by a peer-outreach worker in early 2016, and a pharmacist in 2018.

Today the ARCH team emphasizes **relationship-building** for patients at risk. The particular activities we engage in depend on each **patient's needs and priorities.** Among the services we offer to eligible patients are the following:

- Alcohol/substance use stabilization (e.g., withdrawal management, opioid agonist treatment and other medications, a managed alcohol program, counselling, peer supports)
- Social stabilization (e.g., obtaining ID, applying for income support and housing)
- Health promotion (e.g., harm reduction supplies, STBBI screening, vaccinations)
- Coordination of post-hospital community-based support (e.g., reconnecting with primary-care provider, referral to outpatient-addiction programming).

Our timeline: Collaborating, evolving, adapting

	2008	2013			
		January	**July**	**August**	**December**
Events	Edmonton Inner City Health Research and Education Network (EICHREN) starts	Inner City Health and Wellness Program (ICHWP) funding application successful	ICHWP planning / consultation begins		Assistant Medical Director recruited
Facilitators	Royal Alexandra Hospital Foundation (RAHF) funding $240,000	RAHF funding $3.5 million	Independent funding	Royal Alexandra Hospital (RAH) Senior Leadership support space	
Outcomes	• New network • Awareness/interest • Needs assessment • Community Advisory Group (CAG) & Community Liaison (CL) partnership			Vision champions ID of unmet provider needs	Addiction expertise Shared mgmt. load

	2014			2015		
	January–June	**July**	**August–December**	**January**	**April**	**July–September**
Events	• Clinical staff hired: Administrative Assistant, social worker, & nurse practitioner • MDs recruited • Research staff hired	• Program launch • Discharge injection supplies • Naloxone kits • Opioid agonist treatment (OAT) • Homelessness Transition Coordinator (Human Services) position	• Evaluation begins; PRIHS application (Partnership for Research & Innovation in the Health System: Alberta Innovates) • Inpatient injection supplies • Additonal 0.5 FTE research assistant hired	Masters student starts practicum: hired on as knowledge broker in May	PRIHS funding start	• PRIHS staff hired • Addiction Counsellor hired
Facilitators	• Orientation (College of Physicians & Surgeons of Alberta, Boyle McCauley Health Centre, Streetworks) • Executive Director for navigation	• Branding: logo, lanyards • Champions • Partnerships • Space & infrastructure • RAH Pharmacy	• In-kind supports • Academic partnership			PRIHS funding
Barriers	• Limited expertise with regards to Alberta Health Services (AHS) policies • Administration time	IT / connectivity	Data sharing between partners			
Outcomes		Trust of the ARCH team by front-line clinicians and patients	Robust linked dataset	• Awareness • Branding • Team capacity • Stronger network	• Team capacity • Patient modeling	Increased research / clinical capacity

	2016				2017	
	April	**July**	**October**	**December**	**January**	**April**
Events	• Scientific director appointed • Permanent AHS funding • Peer Support Worker (PSW) hired	RAH senior leadership oversight	Program manager appointed	• Alternate Relationship Plan (ARP) begins • Inpatient Managed Alcohol Program	Administrative Assistant hired	• Team moves into single co-located space • Hospital-wide standardization of CIWA: Clinical Institute Withdrawal Assessment (alcohol) protocol • Supervised Consumption Site application
Facilitators	• Strong hospital/university partnership • Research data • Existing team to support PSW role • PSW training • CAG mentorship	Champions		• Research data • Formal policies and procedures		
Barriers	Few precedents within AHS for PSW role			Policy / legal review		
Outcomes	• Sustained team • Team capacity • Extension of RAHF funds	Program remains responsive to local needs	• Dedicated manager • Shared mgmt. load	Increased MD capacity		• Efficiency • Coordination • Collaboration

Putting ARCH into action: What we did, what you can do

ARCH: Actions that can make a difference

Take stock of your vision, goals & values

Action 1	Action 2	Action 3	Action 4	Action 5	Action 6
Engage your community	Build relationships & partnerships	Create a safe emotional culture for your team	Develop self-care skills for team members	Manage the workload & create job satisfaction	Find resources & funding

Create an effective team & map your environment

Action 7	Action 8	Action 9	Action 10	Action 11
Grow leaders from within	Work as a team	Foster team growth with onsite resources	Consider features of your context	Map your environment

Support quality improvement (QI)

Action 12	Action 13	Action 14
Select ways to measure success	Determine what to measure	Celebrate early wins

Take stock of your vision, goals & values

Action 1 Engage your community

Growing the ARCH network

The ARCH team and its diverse activities developed over time. We took seriously the substantive input from inner city patients and community members with lived experience. We drew on the expertise of the RAH and broader health system stakeholders. We also considered the voices of many external inner city stakeholders (e.g., front-line and administrative members of Edmonton's health and social services, police, government, academic, and nonprofit sectors).

Consolidating needs through focused discussion

In August 2013, stakeholders met for a full-day roundtable discussion on ideal acute care-based services for the inner city community. Our stakeholders from across the province helped us consolidate our ideas about what was needed. They emphasized the need to incorporate best practices in addiction medicine and the social determinants of health into traditional medical approaches. They also stressed improved communication between patients, healthcare providers across the system, and community-based supports.

Interviewing stakeholders face-to-face

Our research arm carried out 1-to-1 stakeholder interviews in early 2014. Our goal? To get feedback on the proposed model of care. We also wanted to ensure that our proposed team activities aligned with the priorities and outcomes our community and stakeholders had identified. The interviews allowed us to explore barriers to implementing our model, the role of facilitators, and ideal approaches to future program evaluation.

Meetings with our Community Advisor Group

In tandem with these activities, the Community Advisory Group—composed of inner city community members with lived experience of the health care system—began to meet quarterly. Members of this group provided critical insights into program development through the eyes of the patient.

Improving processes

Demand for services quickly exceeded supply, which led to refining the ARCH referral process and liaison with other patient supports. Improving our process required developing a close working relationship between the ARCH clinical team and research and QI colleagues (who are integrated into the same program and location).

Complex health-systems interventions never occur in a vacuum.

Making formal partnerships

ARCH's numerous formal partnerships include communicating regularly with the RAH social work team, weekly case conferencing with the Boyle McCauley Health Centre, Navigator for Alberta Community and Social Services, having direct access to Homeward Trust's Housing First Intake System, drawing on the expertise of a liaison at AHS Environmental Public Health and the Edmonton Police Service, and having access to seconded free legal services.

Identifying ARCH champions

Word of mouth and formal presentations (via our front-line staff and our leaders) are some of the strategies we used to identify ARCH champions.

Reinforcing stakeholder relationships

Over time we strengthened our stakeholder relationships in Edmonton, Calgary, and later, throughout greater Alberta. We worked on building connections through word of mouth, unit-by-unit visits, and formal presentations, via our front-line staff and our leaders. We continue to reinforce our networks through our website, newsletter, and social media.

Action 2 Build relationships & partnerships

Creating effective relationships was key to the success of ARCH. Understanding our partners, through meeting, talking—and especially, listening—was an essential step. To get a sense of the "why" behind what our partners had to say, we used several qualitative and participatory approaches.

Focused ethnography

Focused ethnography helped us understand **ARCH patients** who shared **common behaviours and experiences.** Focused ethnographies can be quite valuable for collecting rich data during short-term field visits. Because they generate detailed data and can be time-intensive, we found it useful to focus our inquiry in advance. We prepared a set of **pre-determined questions** to help us investigate the background, actions, social situations, and typical interactions within this group.

Participatory research

To engage the inner city community and help to ensure intervention uptake, we used a **participatory approach to create a co-designed intervention.** We consulted a **community advisory group**—including a community liaison member—each quarter throughout the ARCH project. This group **provided us with guidance in designing, implementing, interpreting, and disseminating knowledge** to the broader community.

A significant proportion of Edmonton inner city patients self-identify as First Nations, Métis, or Inuit background. In keeping with the recommendations of Canada's Tri-Council Policy Statement, "Ethical Conduct for Research Involving Humans" (CIHR, 2014), we ensured that the **majority of participants** on our community advisory group **were Indigenous.** Throughout ARCH's implementation, we sought their input as it related to issues and questions pertaining to Indigenous people.

Stakeholder interviews

To **evaluate** the implementation process and acknowledge its **strengths and weaknesses** for the future, we conducted in-depth **interviews with stakeholders** who work alongside the ARCH team in the hospital (internal) and in the community (external).

Reference

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2014.

How do you ask about substance use in a way that is patient-centered? In a way that will elicit a useful response?

Patient-provider relationship

Strengths of ARCH: What internal & external stakeholders told us

- Patients feel less judgment
- ARCH handles complex patients
- ARCH is an additional resource in a resource-scarce climate
- ARCH and its Transitional Clinic provide continuity of care
- ARCH helps people who traditionally are underserved
- ARCH communicates well with other hospital staff
- ARCH builds trust/rapport with patients
- ARCH builds capacity in the hospital to care for patients with substance use disorders
- Hospital staff were really pleased with ARCH's prescribing behaviour (to manage withdrawal)

Harm reduction works for patients

Some adjectives stakeholders used to describe ARCH:

- Compassionate and caring
- Accessible
- Honest
- Comprehensive
- Outstanding individual team members
- Flexible
- Grassroots innovation
- Changes lives

How patients talked about ARCH

- Made me feel respected, not judged
- I was able to trust them
- Supported shared decision-making and encouraged me to be involved in my care
- Gave me the supports I needed to reach my goals

Steven's story

And that's basically what I got from ARCH was … we're here if you need us. And that to me is amazing. Some people have that ability, some people don't. And like I've said so far everyone that I've met through ARCH has been like that. No one's put me down, no one's belittled me, no one's made me feel less than.

I used to think of myself as a BIC lighter. When people are done with me, they toss me away. You're only useful a certain period of time. I don't feel that way anymore.

Community-team relationship

How do we engage with the community without offending? How can we be open? How can we always be on the side of the patient? How do we create an environment that is inclusive and welcoming? These were some of the questions ARCH explored.

Our team works together to find people who are hard to find, lost to follow-up, or can't be reached by e-mail or phone. Our community-outreach team members will go out and find these patients—helping them navigate care. Our team also provides advice about how to engage people with active addictions, challenges with mental health, or who are homeless.

Some of peer support team members combine addiction lived experience and professional harm reduction experience. They fight every day to influence professionals to look differently at people who use substances and to leverage community resources for them—because they know that programs like ARCH can work wonders.

Partnerships through ARCH

- ARCH is connected within, responsive to, and linked to the community.
- ARCH can leverage joint initiatives and bring together resources at the point-of-care, and address medical issues beyond the acute care door, which creates continuity through relationships.
- ARCH knows the service area and the availability of services. It's a very different situation to tell someone to fill meds or visit a shelter when that person doesn't have ID or coverage for it, and the shelter isn't open or they can't access it. This holistic, patient-focused navigation is part of what ARCH provides.
- ARCH helps identify existing gaps or barriers to care within the current service landscape, and among its partners. It is a bridge between acute care and the community.

Action 3 Create a safe emotional culture for your team

Leaders within ARCH, clinical and otherwise, are eager to support their patients, meet their needs, and keep them safe. They also take great care to **ensure that their staff feel mentally, emotionally, and physically equipped to deliver the care their patients need.**

They encourage both staff and patients to express their desires, concerns, and suggestions for improvement. In doing so, leaders lay the groundwork for creating a safe emotional culture within the hospital.

Cultural change is linked to site culture. The nature of care provided at the RAH set the foundation for ARCH. The RAH leadership has always had a strong focus on improving both the patient and provider experience.

ARCH has encountered resistance from some front-line clinicians who were apprehensive about the change. Thanks to active support from RAH leadership, the ARCH team was able to address and assuage front-line concerns and encourage greater acceptance over time.

As ARCH expands to other units and sites, there will be more than one point-of-contact for patients to get help. **By educating staff on harm reduction and patient wellness, ARCH can foster a new feeling of safety and competency within the hospital.**

Over time—as the tenets of harm reduction are understood and accepted—staff will feel that the hospital culture fully supports their work. It is important that all members of the ARCH team feel accepted and valued for the knowledge and skills they contribute to the team.

By fostering an emotionally safe environment and culture within the team, ARCH staff can have transparent, vulnerable, and authentic interactions with one another. This allows individuals to feel emotionally open to sharing their concerns or struggles. Promoting a culture of mutual respect also encourages team members to remain open to solutions suggested by other hospital staff.

Opportunities to share are available to all ARCH team members during bi-weekly team meetings, one-on-one meetings with ARCH leadership, and/or daily ARCH team huddles. Outside of the hospital, staff enjoy the opportunity to emotionally recharge together at social events (e.g., annual holiday party and summer BBQ). Strengthening interpersonal relationships among ARCH team members can build a cohesive team, and ultimately help shift hospital culture towards becoming more accommodating, accepting, and emotionally safe.

Action 4 Develop self-care skills for team members

While caring for others is extremely rewarding, to do this work well, it is **critically important to care for oneself.** Many of our patients have experienced repeated episodes of trauma, and in the course of caring, these experiences are sometimes shared. These experiences, and repeated exposure to other triggers of stress, such as intense workplace demands, put **team members at risk of compassion fatigue.**

It is very important for leaders to make the health of team members a key priority. Self-care skills need to be woven into the everyday culture of the team. Team members need to support each other and take care of each other.

Debriefing difficult situations is essential. Professional support needs to be made available for the team as a whole and/or individual members—as early as possible and as often as needed. Discussing professional boundaries as well as **setting realistic goals** for team performance and patient outcomes is also important.

Team members are strongly **encouraged to exercise, leave work on time, and to make their health a priority.** Annual team retreats also serve as a way to reinforce this core team value by integrating self-care activities into the day.

Role modeling by senior team leaders is important. This includes not expecting replies to emails sent in off-hours, taking vacations regularly, and sharing personal strategies for managing workplace-related stress. Leaders should be **vigilant for the early signs of fatigue or burnout** in team members.

While "compassion fatigue" is usually applied to front-line caregivers, it is critical to remember that **research and education members of the team may also be affected.** In fact, these team members may be even more at risk. They are typically unable to intervene and do not have the ability to provide direct patient care and see patients improve.

Reference

Nolte AGW, Downing C, Temane A, Hastings-Tolsma M. "Compassion fatigue in nurses: A metasynthesis" J Clin Nurse 2017;26:4364-4378.

Action 5 Manage the workload & create job satisfaction

The workload for ARCH team members can vary, depending on their role and responsibilities, and on the availability of staff at the clinic. It can also shift throughout the day, week and year. **When workloads increase and become heavy, it is important that ARCH staff are equipped with the tools and resources they need to manage their workload efficiently and effectively.** If the issue is left unaddressed, heavy workloads may lead team members to burn out, and ultimately, decrease workplace satisfaction.

Over the past few years, the demand for ARCH consultations at the Royal Alexandra Hospital has increased. As a result, additional clinical staff were hired to meet this need and to relieve current staff of heavier-than-normal caseloads. **New staff were given orientation training and resources to help them transition into their new role on the team.** Once these team members became accustomed to their new roles within ARCH, the workload became more manageable because everyone shared cases, tasks, and responsibilities.

Strategies for workload management have helped address heavy workloads among our ARCH team members. **We stress the importance of small things that add up:**

- Giving team members the ability to prioritize their tasks as they see fit
- Working with team members to defer or decline tasks as needed
- Setting aside scheduled time for administrative tasks
- Taking breaks and planning vacations
- Asking for assistance

We support all staff members in finding ways of managing their workload as they deliver excellent patient-centered care. However, at times, when clinic schedules are full and the demand for ARCH consultations is high, team members may experience unavoidably heavy workloads.

There are also times where adverse patient outcomes can be traumatic for staff who have built a relationship with that patient. ARCH leadership strive to ensure that high-workload periods are infrequent and that there are resources in place to support staff members during difficult times.

How well team members manage their workload can influence how satisfied they are with their role within ARCH. If workloads are balanced and allow time for designated health and wellness breaks, ARCH team members are more likely to feel rested and energized throughout the day.

A well-managed workload also means that ARCH staff can take the time to provide attentive and tailored treatment for each of their patients. Providing staff with a lower-stress, emotionally safe environment not only enhances their ability to meet patient needs and improve patient experience, it also boosts their job satisfaction.

Action 6 Find resources & funding

The ARCH program was many years in the making and the resources required were pieced together over time. **The first and most important step was making deep and meaningful connections with the community.** This was critical to developing a sense of purpose and a clear vision for change. ARCH would not have been possible or successful without the direct input and support of the community it serves.

Early grants were critical for demonstrating the need for the program. We found that seed grants may come from many sources—including **university departments, physician associations (local and national), strategic clinical networks, national research organizations, studentship awards and hospital or other foundations.** Modestly sized early grants can allow a team to generate case-building pilot data that can be used to support larger grant applications.

With enough **pilot data,** it is often possible **to secure a larger grant** that can be used to generate or explore the core components of a desired local program. For example, these components might include:

- Detailed information on the services that patients want to see offered
- Barriers to healthcare access by specific patient groups
- Costs associated with the maintaining the status quo

These larger grants may be used as in-kind funding, which can open up new doors to even more grant opportunities.

As you refine your service-delivery model based on local data, **key funders** to approach for clinical programming include **the health authority and the hospital foundation.** We started the ARCH program with a $3.5 million-dollar grant from the Royal Alexandra Hospital Foundation. We later transitioned to permanent Alberta Health Services funding. **We were able to expand our team further with new funding provided as part of Alberta's Opioid Emergency Response.**

The ARCH program also benefited tremendously from **in-kind support.** This came **from complementary government portfolios (e.g., social services), community organizations, and other parts of Alberta Health Services.**

What helped us find resources and maintain partnerships over time?

- *Presenting* widely on the positive change that our program brought to the community
- *Taking* the time to develop meaningful relationships across the province
- *Finding* a common sense of purpose among the many members of our network
- *Fostering* a culture of excellence within our team and across our delivery of care

Piecing resources together

ARCH early grants

Royal Alex Hospital Foundation

$240,000

to develop a community network (Edmonton Inner City Health Research & Education Network) and collect data needed for larger grants.

Royal Alex Hospital Foundation

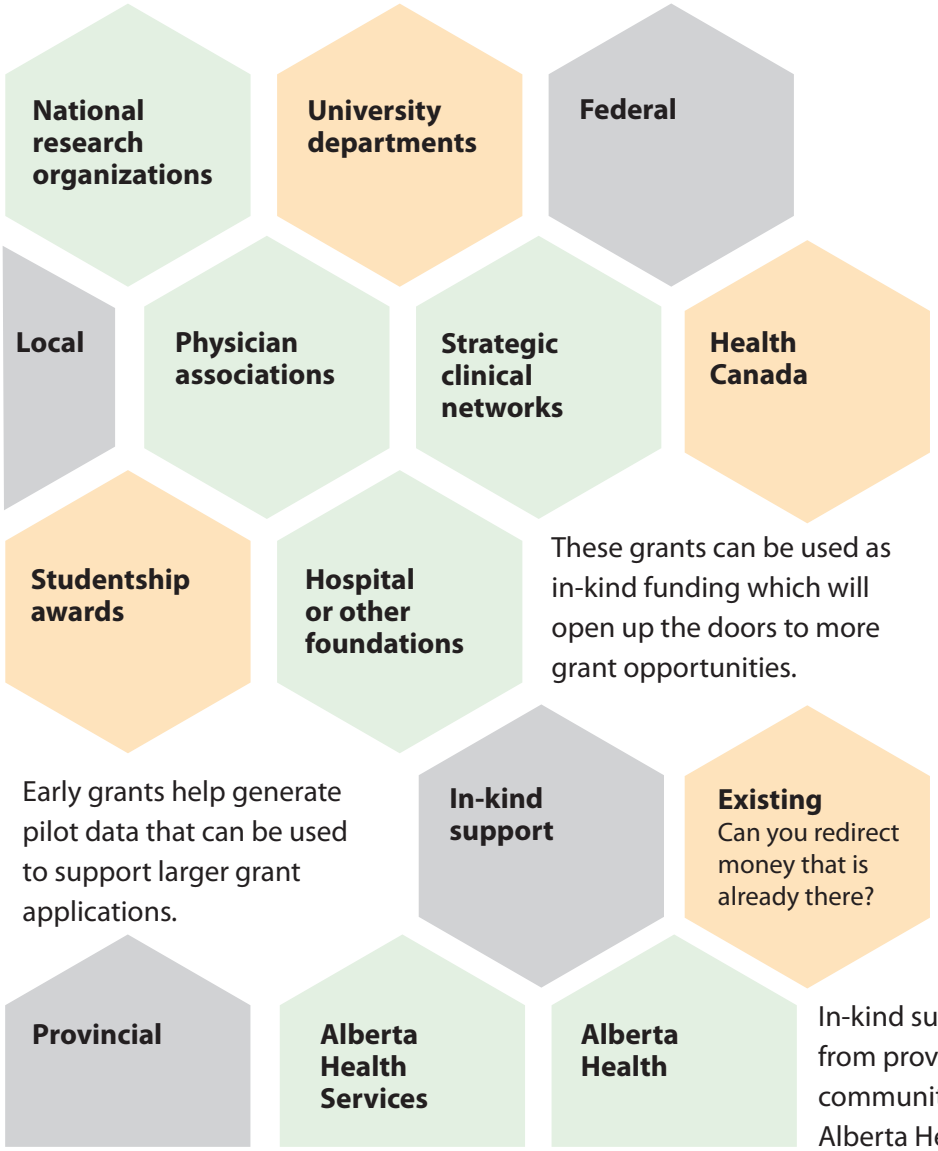
$3.5 million

PRIHS (Partnership for Research & Innovation in the Health System) grant

$750,000

Alberta Health Services
Addiction & Mental Health Strategic Clinical Network Grant

$50,000



These grants can be used as in-kind funding which will open up the doors to more grant opportunities.

Early grants help generate pilot data that can be used to support larger grant applications.

In-kind support can come from provincial ministries, community organizations and Alberta Health Services.

Think about sustainability

What sources are renewable?

What costs are initial, which are long-term?

What capacity do you need long-term?

Start sustainability planning early with key stakeholders

Create an effective team & map your environment

Action 7 Grow leaders from within

The grassroots nature of ARCH called on us to grow our leaders from within. Overtime, our leaders found that a few key principles helped guide them as they developed and managed the program

Leadership takes time. The ARCH program did not start with its leaders already knowing how to create and maintain an effective team. In fact, developing leadership skills and building a cohesive team took time. Although being placed in a leadership role can be very exciting, making decisions that will impact your program can make one feel uncertain, even vulnerable.

We found that listening to team members and their front-line perceptions of hospital problems (and proposed solutions) was key. These conversations prompted leaders to start thinking deeply about the problems at hand.

Sometimes the leader's role is convincing people who are not on the team to look at an existing problem with new eyes. In this case, we wanted to change how we managed and cared for patients living with substance use. We needed others to embrace our vision of ARCH and help them see that our team was up to the task.

Small conversations can have a bigger impact than you might think. Sharing the details of our vision was persuasive. Our advice? Leaders don't need to show up with all the solutions. Instead, they can grow leadership skills as they engage with others—defining and redefining problems.

Push gently to encourage new perspectives. The ARCH leaders found it important to build their agenda gradually. Leaders outside of the program were not always aware of the growing body of evidence that supported our program's vision. Push gently. Once leaders commit to something small, they are more likely to commit to something big. Start with "can we at least try something?"

Not every leader knows the right people who can help move an agenda forward. To see an old problem differently, leaders need to consider the diverse perspectives of others who have a stake in the agenda. That means listening to the voices of all stakeholders—front-line nurses, physicians, patients, other managers, counsellors, and people from community agencies.

Doing the right thing often means confronting a culture of "no". Sometimes, hearing that we are doing the right thing can be incredibly powerful, particularly when we are immersed in a culture of "no." Many organizations, especially large ones, have a culture of "no"—an automatic and unconscious rejection of new ideas and approaches. When confronting a culture that is reflexively negative, we have to expect that the first response will be no. And alas, so will the second.

Large organizational cultures—such as healthcare systems—make it tricky to get to "yes". These cultures often value criticism and rigorous analysis as they make complex decisions. To make matters worse, most decisions require multiple approvals. Not surprisingly, when it is easier to say "no", it makes "yes" much harder. ARCH leaders had to prepare for those difficult conversations in which everything we proposed seemed like an untested idea.

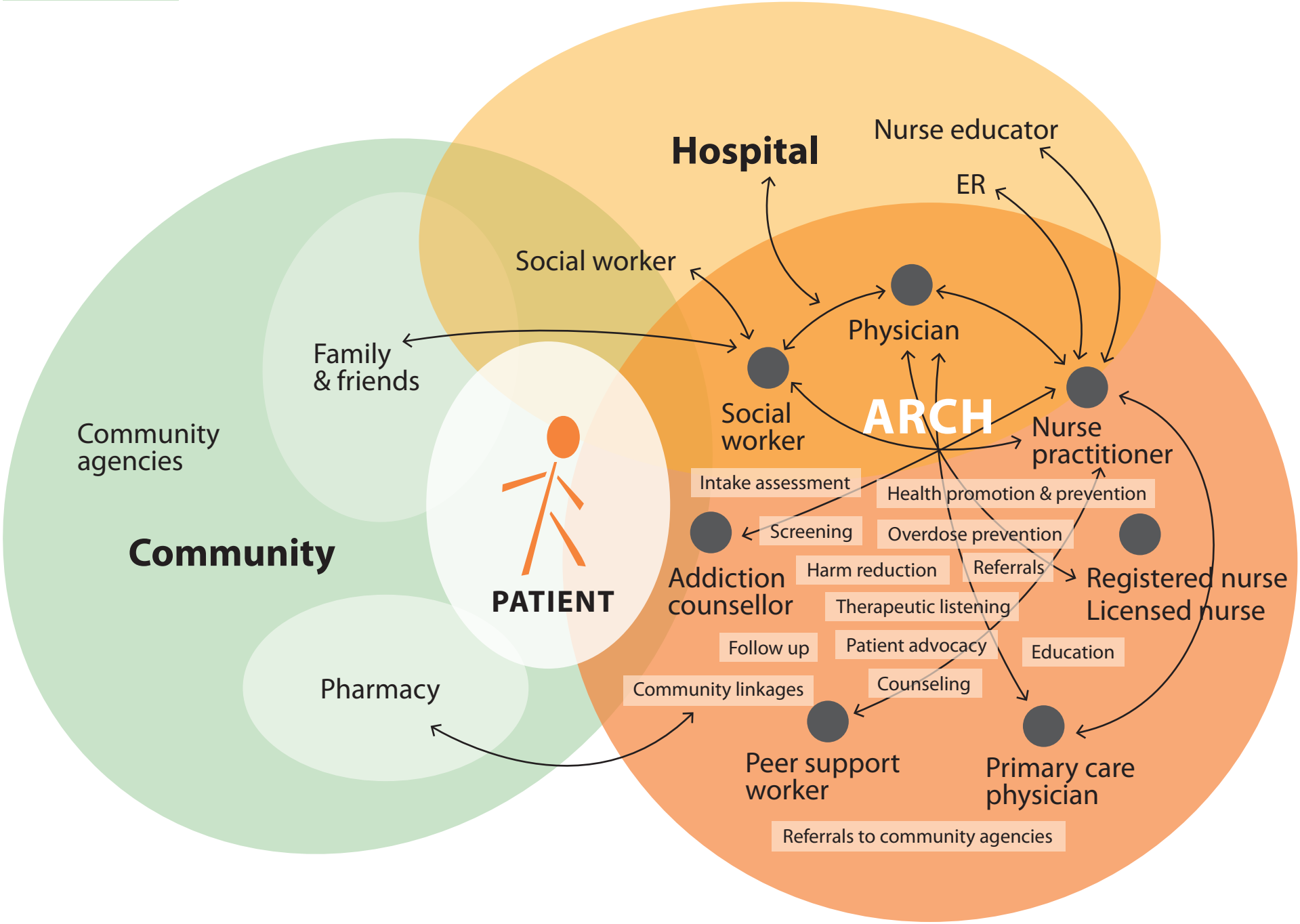
The culture of "no" seems to be related to what people fear. We needed to figure out why people thought that trying something new was so risky. To get leaders outside of ARCH to "yes" required a lot of conversation. And a lot of repetition. It took time for us to understand, "So this is what you are really, really worrying about." You never get to that understanding by flipping through a PowerPoint presentation. You get to it through dialogue and conversation.

One thing ARCH did very well was to take time to talk with everyone who would listen—day and night—about what this program could mean. Listening helped us gradually chip away at the culture of "no". For example, we addressed the culture of "no" when we introduced the provision of harm reduction supplies in the hospital. We needed to directly confront unit-level anxiety about the impact on practice. We worked on creating awareness and support of practice impact, which both promoted unit staff buy-in and had a net positive impact on patient experience.

Sell the problem not the solution. A good way to get through to leaders is to help them to **understand the problem, rather than to offer a solution.** Be prepared to describe the problem succinctly and expect leaders to challenge your ideas with "why is that problem important?" and "why do we need to solve it now?" As William Bridges once said, "People are not in the market for solutions to problems they don't see, acknowledge, or understand". To lay the groundwork for the solution you imagine, we recommend building the foundation by selling the problem.

…We addressed the culture of "no" when we introduced the provision of harm reduction supplies in the hospital. We needed to directly confront unit-level anxiety about the impact on practice. We worked on creating awareness and support of practice impact, which both promoted unit staff buy-in and had a net positive impact on patient experience.

Action 8 Work as a team



Considering team roles

Values guiding our team's activities

- Hospitalization offers an ideal opportunity to intervene, offering a safe place help someone stabilize their substance and/or alcohol use
- Patients in hospital can get other health care needs met, needs they are unable to have met in the community (for a variety of reasons)
- A hospital setting provides a good place for opportunistic screening and treatment (e.g., sexually transmitted infections)
- Patients with substance use disorders often need help with their overall health, making a team approach crucial
- Our team does not ask that patients seek abstinence before we offer them care
- Harm reduction strategies are critical for helping patients engage with care and for building trust
- Harm reduction also means offering a supervised service for consumption, a syringe exchange program, a managed alcohol program, and giving out overdose response kits and condoms
- We believe that helping patients use more safely is just as important as helping them to stop using drugs

Robert

67 year old male with severe alcohol use disorder, multiple falls and ED visits in the community; frequently left hospital against medical advice.

Required admission to hospital for failure to thrive, experiencing multiple falls.

Evicted from housing due to increasing care needs.

Continued to drink alcohol while admitted to hospital, often intoxicated.

Had no desire to stop drinking—had been drinking since age 8.

Started on managed alcohol program and was able to stabilize on 5 standard drinks per day.

Continued purchasing additional alcohol on occasion, but improved once patient agreed to have funds dispensed as gift cards.

Completed entire hospitalization and transferred to managed alcohol program in community.

Since then no further hospitalizations related to alcohol use, health improved.

Peer support Worker

As a Peer support Worker, I offer patients **emotional support—based on my own lived experience with substance use and my own ongoing journey of recovery. I also keep patients company when going to appointments, such as doctor visits, income-support applications, and registries for ID.**

I provide harm reduction supplies and education. I help patients gain access to hospital resources, including the library, chapel, smudge room, computer room, and pet therapy. I walk them through getting government identification and AHC cards. Additionally, **I educate front-line healthcare workers on harm reduction and dealing with difficult behaviours.** I work closely with all staff in the hospital to be the face and voice of our patients. I act as a bridge between our patients and staff as well.

Karen's story

I recall one patient in particular who came in with an opioid use disorder. **She had lost everything, including custody of her children.** When our team first met her, she was in severe withdrawal.

I started with a request to build rapport with this patient from our team doctor. Once we established a meaningful connection, she became more open to working with the rest of our staff.

For a while, she used our harm reduction supplies. Then, thanks to our medical team, she got started on methadone. She had a history of leaving treatment against medical advice but did finish her antibiotics.

For the next few months she would come back in and out of the hospital and we would continue our patient care relationship.

With the support of our social worker, we were able to get her housed. I helped her get a government identification card and took her to medical appointments.

I am happy to say that it has been 10 months since she last came into the hospital. Last week she bumped into me at a store and had her children with her. She was very happy and looked so healthy. She introduced me to her children and told me about her successes. I reminded her of all the hard work she had done. She continues to contact our team and update us on her ongoing road to recovery.

We can make a greater impact on patient experience when we include people with lived experience as team members.

Branding the team

ARCH is an open door— a new approach to caring for patients with substance use disorders. The ARCH team offers a unique experience for people who use alcohol and drugs. Patients receive not only access to evidence-informed therapy, but also to humanistic care and support. This is why an open door is part of the ARCH logo.

But the ARCH team knows that branding is about more than having a logo. Patients today search for healthcare experiences that fit their needs. **That's why personalizing the delivery of healthcare has become a hallmark of the ARCH approach.** The ARCH branding strategy focuses on tailor-made relationships with each patient.

Our goal is to provide the best possible care, for the right patient, at the right time.

To help patients feel comfortable approaching and interacting with ARCH, team members wear bright orange lanyards. These **lanyards are recognized by patients and hospital staff.** They not only distinguish our team, but also foster connections among patients, hospital staff, and our team.

ARCH invites each patient to take part in their own care and to build a relationship with us—as they are, wherever they are, without judgment. Patients learn that we will advocate for them.

Patients recognize that we are different than the care they may have experienced in other settings. ARCH care is less punitive, more compassionate, and more focused on the whole person. **ARCH finds that because patients trust our staff, they come back for care. As one patient put it, "it's always good to see a friendly face".**

Working together

Each of us brings unique skills to the ARCH care team. Together we strive for an ongoing relationship with our patients—**building bridges to connect patients to the services they need.**

Our work is about **collaborating, adapting, and advocating.** We listen to each patient's story, carry out what we are well positioned to do ourselves, then call upon the right team members to carry out other tasks.

Many of our tasks draw our community partners into active care conversations with us. **For a given patient, we might consult with a community pharmacist, an income support case worker, or an inpatient addiction treatment program.** Throughout our care, we navigate the hospital space with patients. We take a trauma-informed approach to care, orienting hospital staff to each patient's back-story.

There is no such thing as a typical day for the ARCH team **because each patient's story and associated needs are unique.** We gather together first thing in the morning to assess what needs to be done that day and delegate tasks accordingly. Over the course of the morning and afternoon, we head out to **see our patients—connecting with team members and other hospital staff along the way.** We typically connect with our colleagues on-the-fly. But sometimes it's important to meet in more formal case conferences or meetings.

Shifting patient needs mean that our workflow changes throughout the day. We regularly reassess our priorities and tasks, asking ourselves, **"What is the best way forward?" We direct our answer to both patient care and team effectiveness.**

Near the middle and end of our day—when time allows—we value reconnecting with other team members. We enjoy debriefing each other about the successes and stresses of the day.

We wrap up by updating **active issues for the next day.** That leads us to end the workday with more routine tasks, finishing our charting, phoning, and faxing.

Action 9 Foster team growth with onsite resources

The ARCH team strives to deliver consistently high quality patient-centered care at the Royal Alexandra Hospital. **To supplement and reinforce our knowledge and skills, we have access to a variety of physical and virtual onsite resources.**

These resources provide the team with helpful information on hospital services and community agencies. They also help us to better support our patients and address their needs because the resources detail the roles and responsibilities of our team and other groups within the Royal Alexandra Hospital.

In Alberta, all AHS staff have access to an online repository containing information and tools devoted to professional competency and growth. Topics include career development, continuing education, performance appraisals, and specialty courses. **There are opportunities for new ARCH staff to receive role-specific training (e.g., peer support worker, addiction counsellor), as well as training in opioid agonist treatment** (i.e., methadone and buprenorphine).

Onsite resources can also move beyond individual professional development to improve the way the whole team functions and collaborates. We find, for example, that having a central gathering space—such as a conference room for meetings and wellness breaks—adds to the quality of our day. It both encourages our team members to grow their professional relationships and provides an informal place in which to foster team comradery and trust.

We maintain a schedule board of who is working each day. It helps cultivate awareness and preparedness within the team. **We create opportunities for ARCH staff to meet with members of the leadership team to voice their questions and concerns. This candid interaction has improved transparency and communal support within our team.**

Establishing a secure computer server where team members can share resources and data with one another allows the team to build collective knowledge and expertise. With these team resources available to us onsite, the ARCH staff feels more confident that they are serving their patients to the best of their ability and with the most appropriate evidence-informed care.

Action 10 Consider features of your context

The Inner City Health and Wellness Program and the ARCH clinical team are part of services housed under Alberta Health Services (AHS)—a province-wide healthcare system for Alberta residents. Since 2008, when AHS officially integrated 12 separate health authorities into one system, it has strived to deliver high-quality care at its hospitals, clinics, and continuing-care facilities throughout the province.

The AHS mission: **"To provide a patient-focused, quality health system that is accessible and sustainable for all Albertans."** This objective resonates strongly with ARCH's goal to address the unmet healthcare needs of Edmonton's inner city community.

They, along with the Minister's Opioid Emergency Response Commission, have also supported the 2018 construction of North America's first hospital-based supervised consumption service (SCS). **RAH inpatients can now self-administer substances under medical supervision while they complete their acute medical treatment.**

We expect that this new service, along with traditional ARCH consultations, will help reduce the number of patients leaving the hospital against medical advice. The service will also assist us in treating unintentional overdoses. In this way, we will reduce the burden on the healthcare system overall.

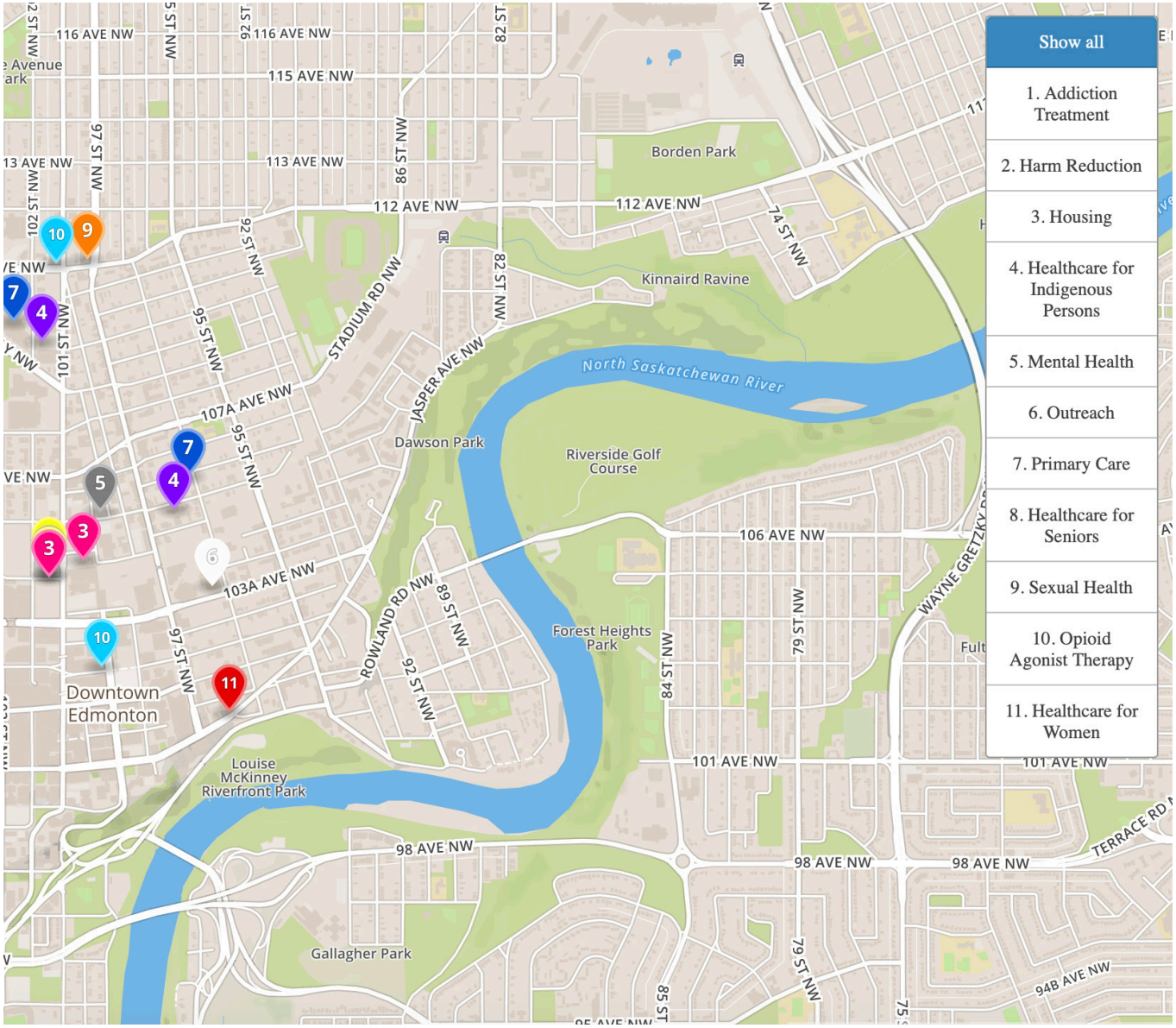
It is important to **consider the unique characteristics of your healthcare system, facility, and program when implementing an ARCH team in a new setting.** Some features of your context to think about include these:

- Program priorities based on your healthcare facility
- Community demographics
- Financial and human resources
- Implementation timelines

When you understand the context of your hospital and community, you will be better informed to design a program that responds to your particular situation. Make sure to follow AHS guidelines when building the team. And don't forget to persevere during those inevitable periods of trial-and-error.

The humble beginnings of the ARCH team—which included six physicians, one nurse practitioner, one social worker, and one administrative assistant—soon grew to a team of over 40 healthcare professionals and research staff. Our mission then, as it is now, is to provide the best in evidence-informed care for our patients who use substances, many of whom have multiple health and social inequities.

Action 11 Map your environment



To get a better sense of potential allies in your community, it's a good idea to identify organizations in your environment who can help your team achieve its goals.

ARCH found it useful learn from the knowledge and experience of community groups and plot the location of such groups on a local map. Mapping your environment can help your team pinpoint both what exists in your community and the gaps in coverage. It also allows you to identify groups who share ARCH's goals and find people who might help your team meet its objectives.

To see what we mean, we provide an example map of the Edmonton environment. We might notice by scanning the map that there are few services available for seniors. This might lead us to consider how to refine our service to address a potentially unmet need. Another look at the map might show new services for people with chronic alcohol use disorder. This would prompt us find out how our team could collaborate with theirs.

Support quality improvement (QI)

Action 12 Select ways to measure success

As we have seen, ARCH is a complex team intervention. Our activities are interdependent—situated in a broad health and social system. In developing ARCH, **we listened to both patients and other stakeholders, allowing us to be responsive and adaptive.** We also drew on feedback as we refined ARCH, helping us to respond more nimbly to changing conditions.

As you select ways to improve your practices, keep in mind that patient and stakeholder feedback is an important way to gauge success. We try to listen early and often. Some of the ways we found helpful include these:

- Formal advisory committees
- Roundtable events
- 1-to-1 follow-up meetings

Getting regular patient input involves setting up well-resourced structures that will allow patients to have an ongoing voice in your work. In our case, **we benefit from a Community Advisory Group,** led by our Community Liaison. The group meets quarterly to update us on trends and events in the community. We listen.

The Community Advisory Group also helps us in other ways, for example:

- Designing new team roles and activities
- Troubleshooting team challenges
- Preparing for evaluation activities
- Interpreting team data

We meet with the group at a time and place that are convenient to them, frequently off-site. All group members are remunerated with cash for their time in participating in advisory activities.

The ARCH team actively participates in QI activities. We are supported in our work both by **robust data sources and dedicated human resources.** Our Unit Manager and Clinical Nurse specialist coordinate QI meetings and team education activities. They also lead hospital-wide education on harm reduction principles.

Our **Research and Evaluation Consultant**—who manages the team's electronic clinical-information system—assists with collecting additional data from patients and staff. The consultant also supports the team in implementing and evaluating improvement cycles.

The clinical team has a close working relationship with local researchers, who often lead formal research on the ARCH team's services. Local researchers directly affiliated with our Inner City Health and Wellness Program also help us address issues of data, ethics, and other questions that arise during QI work.

Action 13 Determine what to measure

Our team values patient engagement. This means we go beyond collecting team-process data and administrative health-service data. We **ask patients directly about their experience.**

On one hand, our administrative data sources allow us to **track health service use and team processes consistently over time.** On the other, our direct patient data sources (e.g., **quantitative surveys, qualitative interviews—using plain language and taking into account literacy level) allow us to make sense of administrative data.**

Our patient surveys and interviews help explain why we are observing certain trends. Direct patient data—obtained as needed from among our caseload—also help us to capture important contextual information that might otherwise be missed. Importantly, when we bring together our quantitative and qualitative data, we can more effectively plan for future delivery of care.

Our stakeholders, particularly community members, suggested measuring a number of processes and outcomes to guide our team's QI:

Process information

- Time elapsed between referral and consultation
- Number and duration of care interactions for each patient
- Services offered and accepted (or refused)

Outcome information

- Health service metrics (such as ED use and hospitalization)
- Patient-oriented outcomes (such as substance use stabilization, housing, perceived unmet needs for care)

A complete list of outcomes that we assessed during our early program evaluation is available in Appendix 3. Future QI and evaluation can be guided by this list. However, we recommend that your decision about what outcomes to assess also be guided by local needs and future population trends.

Action 14 Celebrate early wins

When we launched our clinical service, some front-line healthcare providers expressed discomfort with harm reduction approaches. They felt that the ARCH team's mandate was out of scope for acute care. They were concerned that the hospital might be overwhelmed by patients attracted to our model of care.

Strong leadership, local educational activities, and aligned policy helped the team address these challenges. In addition, **word quickly spread among front-line staff that the ARCH team's earliest patients were stabilizing—both medically and socially. They were also re-presenting to the hospital less frequently. These early successes encouraged more widespread acknowledgment of the team's value within the acute care setting.**

Changing complex health systems and entrenched behaviour is difficult. This makes it important to set small, realistic goals and to recognize success along the way. **Team meetings should include time to celebrate accomplishments. These can be related to patients, research, clinical innovation, or education.**

Nominating the team for awards is also a great way to highlight achievements and boost team morale. Having an award-winning team makes it easier to secure clinical and research funding. But just as important, it highlights how much the team and their work is valued.

Giving public presentations or publishing the latest clinical innovations is important for disseminating the team's work. At the same time, spreading the word also provides an opportunity to reflect on how much the team has accomplished. It offers a chance to **remember what things were like before and how things are different now.**

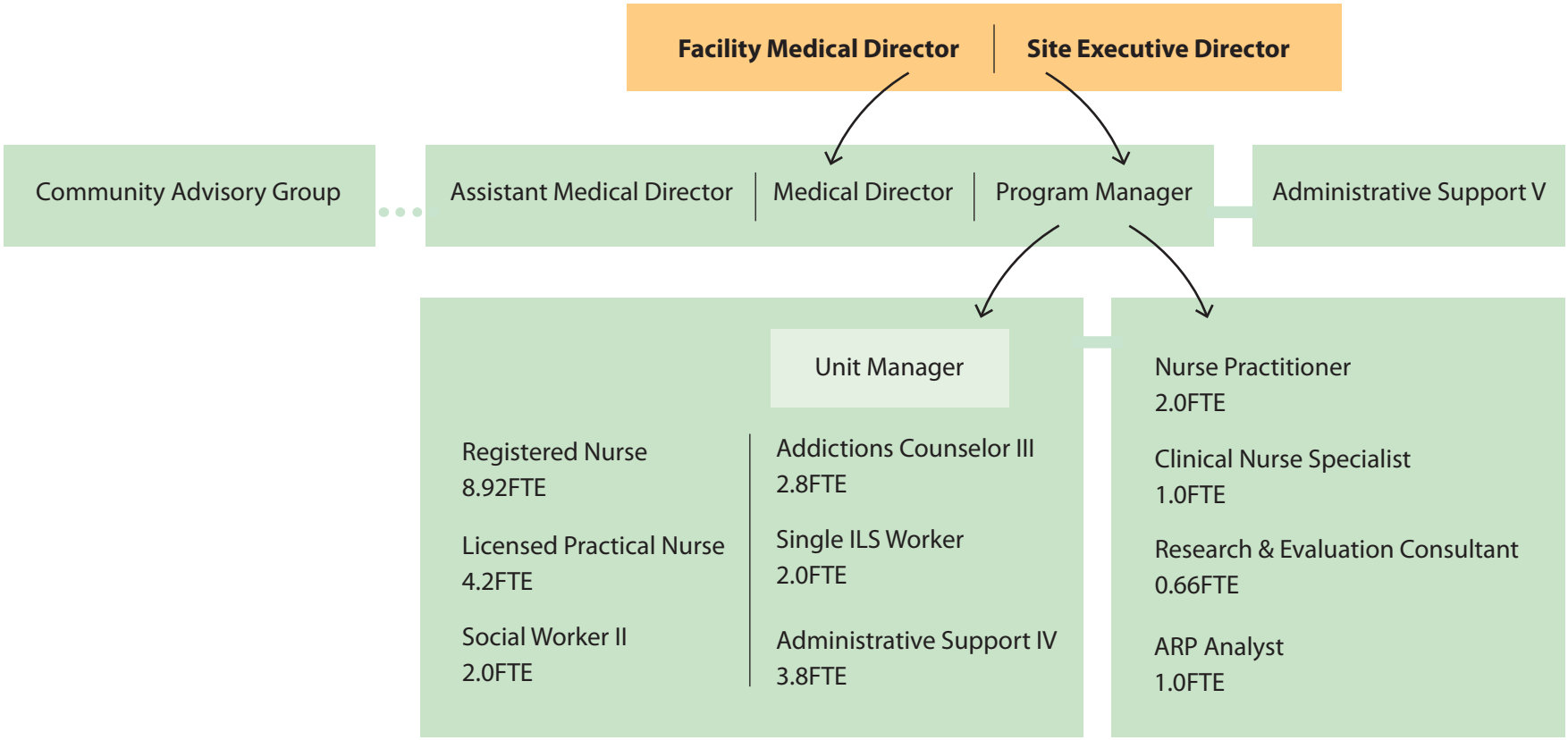
The ARCH team is always looking ahead to improve practice and make a positive impact on the community. Yet they also recognize how **important it is to honour and congratulate the team for each milestone along the way.** Quality improvement takes time and celebrating early wins enriches the journey for everyone.

Closing

The ARCH approach to care is about building relationships. It is about providing compassionate, evidence-informed, wrap-around supports. It is about meeting needs, reducing harm, and finding improved health through shared decision-making and service co-design. We implemented ARCH successfully because we cultivated healthy working relationships with people with lived experience, front-line clinicians, hospital and health system leaders, community service providers, researchers, and most importantly, with each other. We continue to learn from our implementation journey and look forward to learning from others who are starting on a similar path.

Appendices

Appendix 1. Organizational structure



Appendix 2: Roles & Competencies for team members

ARCH uses provincial job descriptions (where available) for base qualifications for staff. This includes: Social Worker, Addictions Counsellor, Nurse Practitioner, Registered Nurse and Licensed Practical Nurse.

All of our job postings begin as follows:
The goal of the Inner City Health & Wellness Program is to provide patient-centered, evidence-based and holistic care to our patients who are socially vulnerable and/or dealing with problematic substance use. By using a co-ordinated, multidisciplinary approach, the team strives to support at-risk patients who want to improve their social determinants of health and/or reduce their substance use.

Hiring into the ARCH team involves ensuring that the candidate has the right philosophy of care. It is expected that there will be some level of education required to support the staff with the addiction medicine knowledge, but if they don't have the right attitude, that is an absolute barrier to hire. It is also an asset for staff to have knowledge and experience with trauma informed care and cultural sensitivity training.

To accomplish this, each posting has the basic requirement:

- Demonstrated experience or ability to practice within a harm reduction philosophy of care
- Minimum 2 years experience working with marginalized/ vulnerable populations

Requirements specific to each role

Peer Support Worker

In hospital support (visits, art supplies, TV/DVDs) | Therapeutic listening
Often act as bridge / "in" for clinical team | Help obtaining ID
Accompany to external appointments | Harm reduction supplies and counselling
Patient advocacy

Competencies

- No formal education required
- The most important qualification: lived experience with substance use, poverty, homelessness, etc.
- At least two years active recovery
- Ongoing recovery support expected
- Self-wellness strategies/ healthy behaviour towards work life balance
- Demonstrated ability to support patients in all stages of change related to substance use

Continues next page

Requirements specific to each role

Social Worker

Collaboration with unit social workers | Outpatient follow up and community referrals
Assistance with housing and applications | Assistance with income support documents
Patient advocacy

Competencies

- Follow the organization's job description
- Member of the relevant Regulatory Body (e.g., Alberta College of Social Workers)
- Experience in assessing and addressing social determinants of health, including housing, income support, medication coverage, and identification.
- Knowledge of relevant agencies and organizations that service patients with active substance use, homelessness, and poverty
- Experience in addiction related assessments and treatment options for patients

Addictions Counsellor

Inpatient counselling and support | Referral to community support services
Referral to inpatient residential treatment centres | Patient advocacy

Competencies

- Follow the organization's job description
- Minimal education: undergraduate degree in addictions or a combination of an undergraduate degree in a related field (commonly Social Work) with coursework in addictions
- Those eligible for registration under the Health Professions Act must maintain active registration (e.g., a social worker functioning in an AC role, must still be registered with the Social Work regulatory body)
- Ability to support patients within the harm reduction spectrum of care; important that the incumbent is able to support patients in situations where recovery may not be realistic or the patient's immediate goal

Nurse Practitioner

Supportive of physician role | Inpatient consults
Comprehensive addiction management | Health promotion
Inpatient follow-ups | Outpatient assessments after ED referral
Referrals to community agencies
Education to unit nursing staff | Patient advocacy

Competencies

- Successful completion of a NP program at a minimum of a Master of Nursing level or equivalent, family/all ages or adult NP.
- Regulatory registration as a practicing NP
- Addiction medicine course/diploma, etc.
- OAT prescribing education and certification (in line with the activities outlined within the relevant regulatory body scope of practice)

Physician

Inpatient consults | Comprehensive addiction management
Inpatient follow-ups
Outpatient follow-ups / bridging for methadone patients
Referrals to community agencies | Patient advocacy

Tasks

- Being the initial point-of-contact for the team
- Completing the initial assessment and building trust
- Developing rapport and discussing treatment options with the patient
- Providing advice about pain and withdrawal management
- Suggesting medications that may stabilize the patient's substance use
- Discussing ways to promote health—immunizations, screening for other infections

New roles during recent expansion

RNs / LPNs

Oversee Supervised Consumption Service
Educate patients in harm reduction strategies
Assist in finding and securing veins | CANNOT pierce skin with a needle, "flag", or inject
Monitor patients post consumption for any adverse effects
Respond and intervene to any adverse events associated with consumption
Communicate with inpatient unit and ARCH team | Patient advocacy

Pharmacist

Liaising with community pharmacy
Education and monitoring of medication dispensing/administration; in particular, opioids, methadone, buprenorphine, and alcohol
Communication with community pharmacies on admission, ensuring prescriptions are held until discharge
Monitoring for drug interactions | Special projects like supervised injectable OAT

Appendix 3: Possible data elements and sources to consider* for program evaluation and QI

Outcome	Variable	Data source
Stable/reduced substance use	Alcohol intake[1]	Survey
	Drug intake[2]	Survey
	Tobacco intake	Survey
	Uptake into addiction treatment	Survey/Health Services[7]
	Initiation of opioid agonist treatment	Survey
	Substance use-related risk behaviours	Survey
Uptake of preventive care	Contraception	Survey
	STBBI prevention	Survey
	STBBI screening	Survey/Health Services[7]
Improved continuity of care	Primary care attachment / continuity	Survey/Health Services[7]
	Emergency department presentations for family practice care sensitive conditions[3]	Health Services[7]
	Premature departure from the hospital	Health Services[7]
Improved social determinants of health	Stable housing	Survey/Human Services[7]
	Stable income	Survey/Human Services[7]
	Valid identification	Survey
	Medication coverage	Survey
	Access to support worker	Survey
	Criminal activity	Survey
	Criminal victimization	Survey
Improved overall health	Unmet need for care[4]	Survey
	Symptoms of depression[5]	Survey
	Health-related quality of life[6]	Survey
	Physical trauma / injury	Health Services[7]
	Hospitalization	Health Services[7]

* As determined by consultation with patients, clinicians, and other stakeholders during program development.

[1] As measured by the Alcohol Use Disorders Identification Test–Consumption (AUDIT-C).

[2] As measured by an abbreviated version of the Drug Use Disorders Identification Test (DUDIT).

[3] Refers to an administrative data partner.

[4] A primary care quality indicator developed by the Health Quality Council of Alberta.

[5] As measured by the Perceived Need for Care Questionnaire (PNCQ).

[6] As measured by the Patient Health Questionnaire-2 (PHQ-2).

[7] As measured by the EQ-5D.

For more information about ARCH

Inner City Health and Wellness Program

B811 Women's Centre, Royal Alexandra Hospital
10240 Kingsway Ave NW,
Edmonton, AB T5H 3V9
(780) 613-5022

contact@ichwp.ca
www.ichwp.ca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