
## Alberta Conservative Kidney Management (CKM) Clinical Pathway

### Alberta Kidney Council, Alberta Health Services (AHS)

The interactive, web-based conservative kidney management (CKM) clinical pathway was designed in collaboration with patients, families, and multi-disciplinary healthcare providers to engage patients who have stage 5 chronic kidney disease (CKD), their families and clinicians in the co-development of personalized, integrated care plans.

The CKM pathway promotes shared decision-making between patient and provider by including a Patient Decision Aid (PDA) designed to help patients decide if CKM or dialysis is right for them. The PDA is based on their responses to nine key questions that explore their individual health and values. This facilitates the development of a care plan aligned with patient values, preferences and prognosis. This pathway also includes patient education materials to promote self-management as well as supportive care tools, such as a crisis action plan.

Results from project evaluation show that patients feel the CKM pathway is improving access to information and healthcare resources and empowering them to make informed decisions about their care. By using this evidence-based, standardized, and patient-focused approach to care planning, 74 per cent of patients reported an absence of severe CKD symptoms (up from 54 per cent pre-implementation).

## City Centre Team (CCT) Mobile Paramedic Program

### Calgary Zone Community Paramedic Program (CPP), Alberta Health Services (AHS) Emergency Medical Services (EMS)

The Calgary Zone Community Paramedic Program (CPP) created its City Centre Team (CCT) mobile paramedic program to address a key recommendation made in the Calgary Recovery Services Task Force's *2016/2017 Final Report and Recommendations:* to provide better access to health services for people living with homelessness. Seeking to provide both improved access and equity to its patient population, this program coordinates a specially trained, mobile paramedic service with existing healthcare resources to deliver timely, individualized care to people living with homelessness where they are. For example, in shelter, harm reduction sites, encampments, or curbside.

With an understanding of harm reduction and a dedication to providing responsive care, the CPP CCT treats homelessness itself as a complex medical condition. To further support this approach, all elements of the program work to mitigate the systemic and organizational barriers as well as the social determinants of health that prevent this vulnerable population from benefiting from traditional care models. Some of these barriers include previous traumatizing encounters with the healthcare system, insecure housing, addiction, and mental health issues that compromise a person's ability, if unsupported, to navigate through the complexities of a healthcare system. In addition to providing urgent and primary healthcare, the program also provides follow-up care and a connection to ongoing care and other supportive services.

Evaluation of this program from patient, physician, and staff interviews indicates that meeting people living with homelessness where they were improved patients' comfort and increased their willingness to receive care. Patients also appreciated the connection to additional supports, including social workers, counseling, and legal services. The CPP CCT has provided interventions associated with an emergency medical service, emergency department, or urgent care avoidance (e.g., intravenous and oral medication administration, wound care, intravenous fluid administration, STAT laboratory specimen collection, or cardiac monitoring) in 65 per cent of the events they attended.

## End of Life Framework and Program

### The Brenda Strafford Foundation

Resident and family feedback, captured through resident experience surveys and focus groups, helped The Brenda Strafford Foundation identify the need to improve palliative care service delivery for their long term care and supportive living residents. With the resident and family voice central to the process, The Brenda Stafford Foundation team developed and implemented a holistic End of Life Framework and Program to address this need.

Using a new tool (Palliative Care "Bullseye" Framework), in conjunction with existing, validated tools (e.g., Palliative Performance Scale (PPS), Personal Severity Index (PSI)) and a multidisciplinary approach, the End of Life Framework and Program has many layers that address all elements of patient experience. These elements include the relationship between their residents and families, clinicians and staff; the physical environment; planning of services; and the delivery of services. To support effective delivery, program staff receive education and support in the implementation of all aspects of this program.

Positive impact on the resident experience has been realized in the areas of communication with residents and their families, notably with respect to end of life conversations; emotional support for families; and symptom management. As a result of the improved support for families, the percentage of family members who participate in providing care to their loved one at end of life has increased. As Medical Director Dr. MaryJane Shankel observed, families have been empowered by taking part in the end of life care of their loved ones.

*"One comment from a family member that most stands out for me was that they felt that this was the 'single most powerful experience in life' that they had ever experienced."*

## Inner City Health and Wellness Program

### Royal Alexandra Hospital, Edmonton

The mission of the Inner City Health and Wellness Program is to provide evidence-based, patient and community-centred, holistic care for patients with active substance use disorders and/or those dealing with social inequity. Through development, implementation and ongoing improvement this program is well-informed by patients, community partners and a Community Advisory Group. The Community Advisory Group consists of community members with lived experience, who the Program staff meet with quarterly.

The Program includes three components: a clinical consult team (the Addiction Recovery and Community Health (ARCH) Team); a research program focused on the development and refinement of leading practices for the care of patients with substance use disorders in acute care settings; and, an education program that translates evidence and leading practice into exceptional care at the bedside.

The ARCH Team provides a range of services to admitted or emergency department patients at the Royal Alexandra Hospital that include comprehensive recommendations for the management of substance use disorders, social stabilization, health promotion activities, and a linkage to community-based and primary care.

Each of these four areas of service includes a number of supporting tools and resources available to address individual patient needs. For example, initiation or maintenance of opioid agonist therapy, help to secure photo identification and Alberta Personal Health Cards, screening for blood borne or sexually transmitted infections, and accompaniment to community-based or primary care appointments when requested.

Numerous patients were willing to share their experience and below is one quote that demonstrates the positive impact this program has on its community.

"*Like, they treated me more than just a number, you know. They treated me like I was a member of their family, a little brother or somebody they actually cared about, which was big time. ARCH is the first organization I've dealt with that I've felt that kind of care and commitment from.*"