Integrated Primary and Community Care In British Columbia: From Policy to Practice

Specialized Community Services Programs for Adults with Complex Conditions and/or Frailty

-Canadian Home Care Summit - October 1 & 2, 2018

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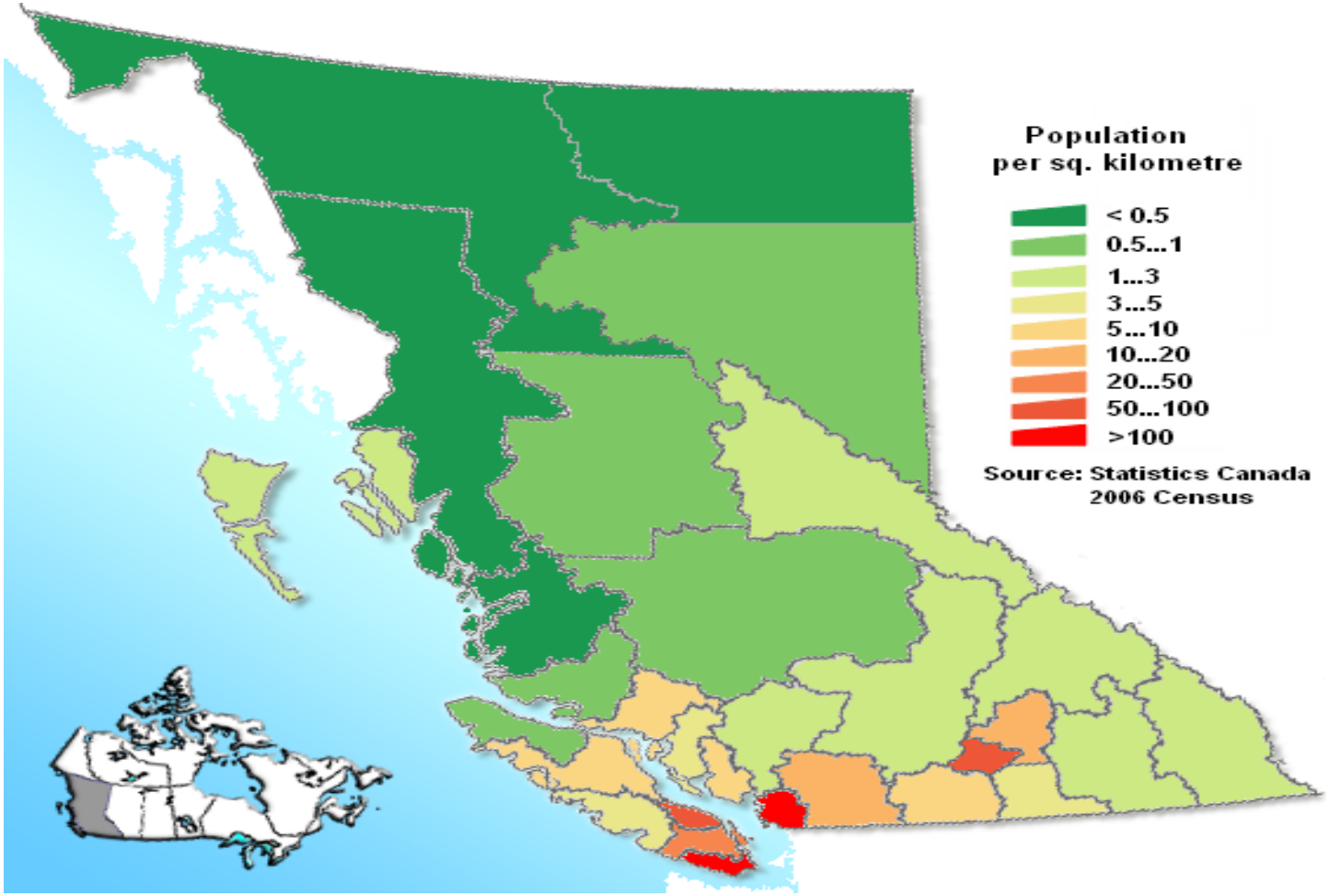
British Columbia, Canada



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Primary Care Networks (PCNs) and Specialized Community Services Programs (SCSPs)

- PCNs are the foundation of the integrated system of primary and community care, intended to better meet patient and family needs by linking primary care providers and services within defined geographic areas through team-based care.
- PCNs will be linked to *Specialized Community Service Programs* (SCSPs) which are primarily health authority managed or contracted services.
- Across BC, implementation is underway for 3 types of SCSP's, MHSU, Adults with Complex Conditions/ Frailty and Surgical Services, with one (Cancer Care) under development.

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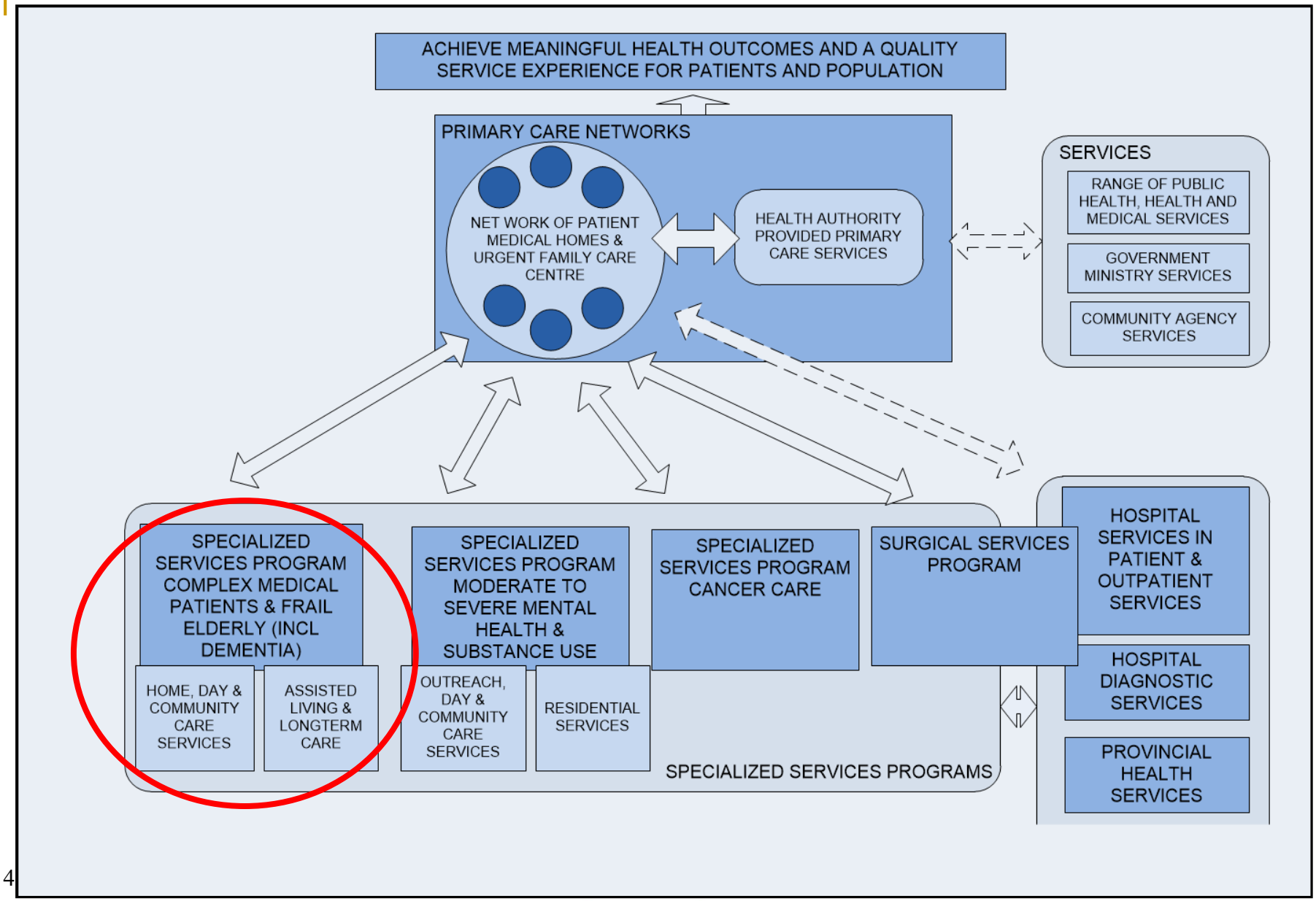
The BC Targeted Operating Model (TOM)



SCSP for Adults with Complex Conditions/Frailty - Policy Direction to all BC Health Authorities

- **General Direction:** Adults with Complex Conditions/Frailty
- **Service/Population Focused Supporting Policy Directions:**
  - Home Support
  - Long Term Care
  - Assisted Living
  - Respite Care
  - Palliative/EOL Care
- **System Level - Supporting Policy Directions:**
  - Development of the Integrated Health System for Primary & Community Care
  - Team Based Care
  - Continuity of Care

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SCSP Design

- SCSP Attributes
- SCSP Expectations
- Guidelines about linkages to PCN's
- Guidelines about linkages to CBP/NGO's

Incorporating:

- Relevant legislation
- Relevant regulation
- Ministry of Health policy
- Provincially mandated directives

- Local operational service design
- Health authority level service design
- Provincial service design

- Provincial performance measures
- National performance measures
- Provincial data collection requirement
- National data collection requirements

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Specialized Community Services Programs (SCSPs) for Adults with Complex Conditions and/or Frailty

- Integrates multiple related population focused services into a single program structure linked to PCNs that meets all of the needs of this population in the community,
- Services include (but not limited to) Community nursing and community allied health services (OT,PT,SW), Home support, Respite Care (Adult day program, in-home and facility-based), Assisted living, Long-term care, Palliative care in all settings, Formal linkages to local community-based/NGO services, and Chronic disease management, and
- Health Authorities are supported to create programs to bridge gaps in the current structures, i.e. – monitoring programs.

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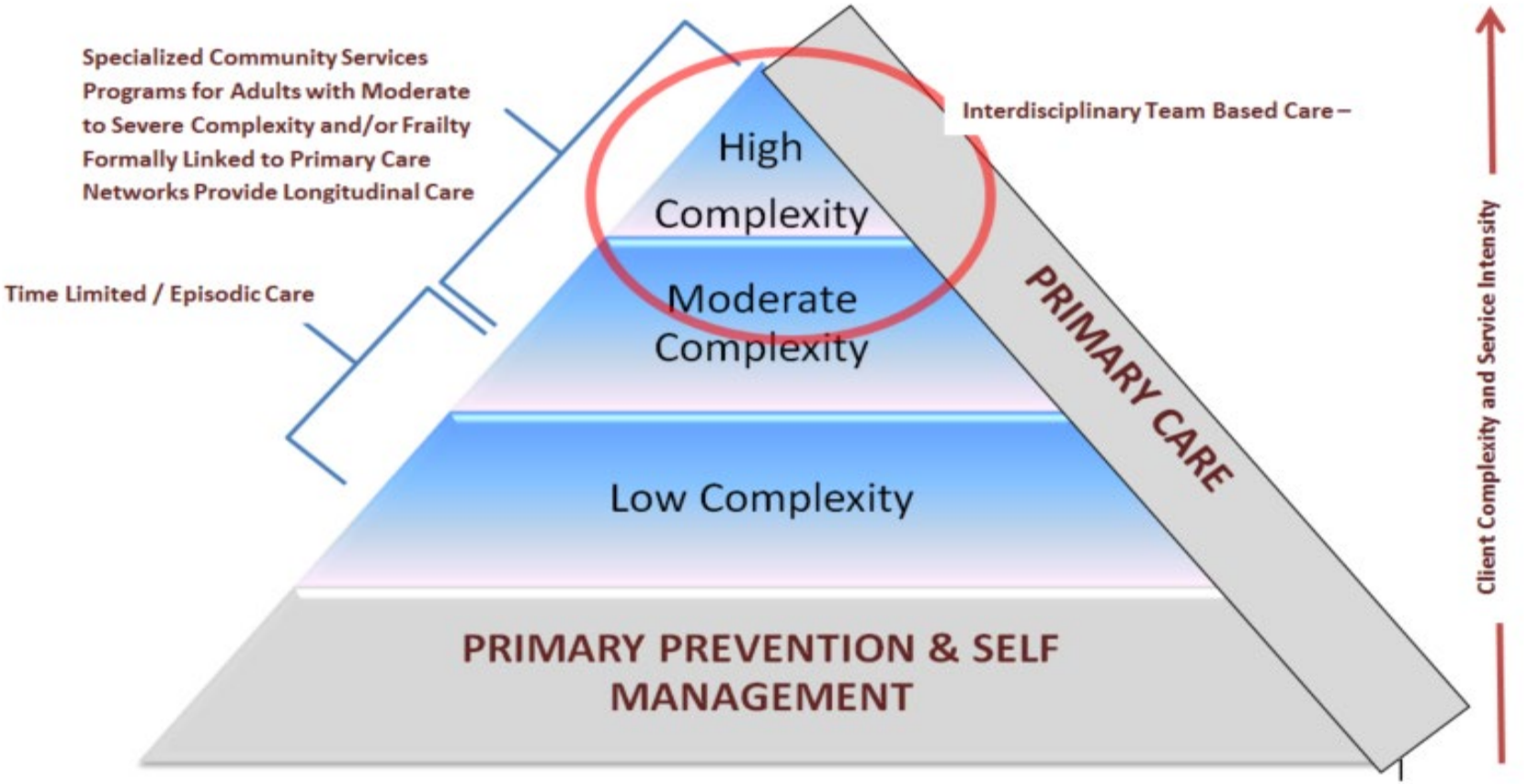
Who Do SCSPs Serve?



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SCSP Attributes: Team Based Care Practices are Enabled and Supported to Deliver Quality Care

- Services are designed into a single population-based program and all access barriers have been removed,
- Interdisciplinary teams possess the competencies to deliver seamless, integrated care, including:
  - Timely access to quality and appropriate services based upon needs,
  - Clinical pathways and protocols support evidence-based care and smooth transitions between all SCSP services,
  - Timely response to unscheduled or urgent care needs to avoid hospital and emergency department admissions, and
  - Services are coordinated and organized to expedite timely discharge from hospital.

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SCSP Attributes: Accessible Linkages Across Primary & Community Care for Clients/Families and Providers

- SCSP's are formally linked to one or more PCN's,
- An easily accessible single point of contact is available for all providers and clients/families, including access to a knowledgeable person to assist with questions as needed,
- A single designated leader within the organization has fiscal and operational accountability for all aspects of the SCSP,
- Access to hospital and diagnostic services is direct, bypassing emergency departments (where clinically appropriate),
- Formal linkages to local community-based/NGO service, and
- Timely and accessible supports for family/friend caregivers.

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SCSP Attributes: Technology supports alternate methods of care delivery and effective information sharing

- Data collection and reporting aligns with federal, provincial and regional requirements, e.g. performance monitoring and minimum reporting requirements,
- An alternate method of care delivery in metro, urban, rural and remote settings, e.g. Home Health Monitoring,
- Communication enabled between teams members and other stakeholders, and
- Information sharing between providers and key stakeholders, e.g. care planning, electronic documentation and remote consultation.

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What is Happening in Home Care in BC?

- Integrating Primary and Community Care services takes significant leadership, planning and collaboration,
- SCSP development includes Home & Community Care redesign to meet the SCSP Attributes for care of Adults with Complex Conditions/Frailty,
- Home Care service delivery, continuity of care and responsiveness to meet the needs of clients and their families are core elements of this work,
- The BC policy direction documents align fully with the 'Harmonized Principles for Home Care' (CHCA, 2013).

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What is Happening in BC to Integrate and Formally Link Primary & Community Care?

- Communities have developed local health authority/Divisions of Family Practice Planning committees called Collaborative Services Committees (CSCs),
- In the spring of 2018, CSC's were invited to put forward a service plan that outlines how they will develop their PCNs and SCSPs within their community in alignment with the model.
- The first 4 communities have been approved and are commencing both PCN and SCSP implementation, an additional 6 communities have just submitted their plans, and
- An additional wave of communities are busy developing their plans for submission by October 1st, 2018.

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