

Integrated Home Care and Primary Health Care

A PAN-CANADIAN PERSPECTIVE

Proceedings from the
2018 Home Care Summit
Panel Presentations



Advancing Excellence in Home Care

The Canadian Home Care Association (CHCA), incorporated in 1990, is a national not-for-profit membership association representing home care stakeholders from governments, health authorities, local health integration networks, service providers, and equipment and technology companies. The CHCA advances excellence in home care through leadership, awareness, advocacy and knowledge.

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Integrated Home Care and Primary Health Care A Pan-Canadian Perspective

Proceedings from the 2018 Home Care Summit Panel Presentations

The benefits of integrated care for older adults living with frailty include: increased quality of life and satisfaction with care, enhanced service coordination, improved health outcomes, reduced duplication of services and a more efficient system. Integrated care in the community—specifically linkages between home care and primary health care—is widely recognized as a vital part of quality care for individuals with chronic conditions, including seniors living with frailty. However, the percentage of primary care doctors who routinely communicate with their patients' case manager or home care provider about their patients' needs and the services to be provided varies widely across Canada: 33% in British Columbia, 32% in Alberta, 58% in Saskatchewan, 36% in Manitoba and 27% in Ontario.

To gain a better understanding of the policy and program direction that jurisdictions are taking across Canada to facilitate integrated care between home care and primary health care, the Canadian Home Care Association (CHCA) hosted a series of discussion panels during our 2018 Home Care Summits in Prince Edward Island and British Columbia. All panel presentations were live-streamed with video content available on-demand. This paper summarizes the key discussions from each panel presentation.

SASKATCHEWAN

Integrated Home Care &
Primary Health Care:
Connected Care Strategy

BRITISH COLUMBIA

Integrated Home
Care and Primary
Health Care: From
Policy to Practice

ALBERTA

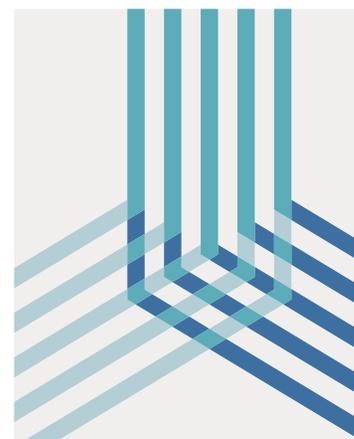
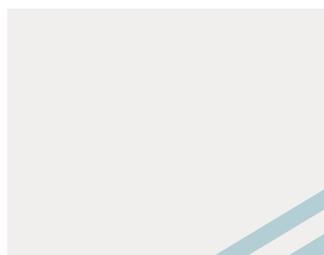
Integrated Home
Care and Primary
Health Care: Rural
and Urban Models

MANITOBA

Integrated Home
Care and Primary
Health Care:
Silos to Integration

ONTARIO

Integrated Home
Care and Primary
Health Care:
Embedding Care
Coordination



SASKATCHEWAN

Integrated Home Care & Primary Health Care: Connected Care Strategy

Host:

ALISON KERNOGHAN – Research/Knowledge Exchange Associate, Geriatric Health Systems Research Group, Faculty of Applied Health Sciences, University of Waterloo

Guest Panelists:

SHEILA ANDERSON – Executive Director, Primary Health Care, Integrated Urban Health, Regina Area, Saskatchewan Health Authority

PATRICIA COMFORT – Director, East Primary Health Care Network, Regina Area, Saskatchewan Health Authority

Saskatchewan's underpinning philosophy for their Connected Care Strategy is to create and sustain "high-quality care transitions" that will reduce reliance on hospital care and shorten emergency department wait times. Spearheaded by the Saskatchewan Health Quality Council (SHQC), the Connected Care Strategy evolved out of the Emergency Department Waits and Patient Flow Initiative. The SHQC used computer modelling to "virtually" test various possible interventions to improve patient flow, while recognizing that a strong team in both hospital and community settings is essential to safe, effective transitions into and out of hospital. Connected Care is now embedded in the 2018–2019 Health System Plan.

Saskatchewan's Connected Care Strategy works to improve:

- team-based care, both in hospitals and in the community;
- ways to communicate with patients and providers; and
- communication when patients move between these settings.

The Connected Care Strategy includes three key focus areas:

- Connected hospital care – Team-based, collaborative care (i.e., Accountable Care Units) improves communication and care coordination, shortens the length of stay and improves patient outcomes.
- Connected community care – Collaborative community-based teams focus on preventing patient admissions to hospital and premature admissions into long-term care, supporting timely patient discharge and maximizing patients' independence so they can safely live in their own homes.
- High-quality care transitions – This evidence-informed approach ensures patients, and their relevant information, are transitioned safely and seamlessly across all care settings.

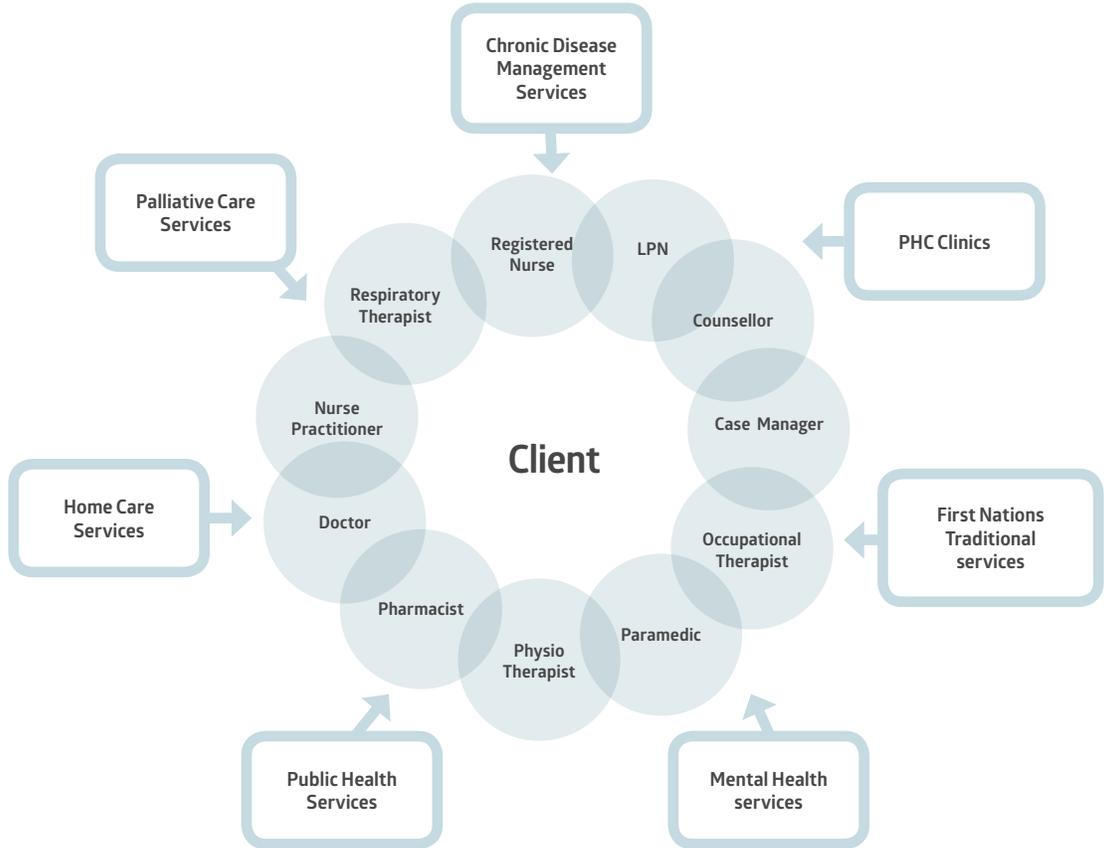
Connected Community Care – Regina Area, Saskatchewan Health Authority

Connected Community Care in the Regina Area is achieved through health networks that foster collaboration between health professionals (including physicians, primary care teams and home care providers) and community partners to meet the needs of individuals and communities. The key factor in this approach to connected care is the emphasis on community and the creation of specific community sectors within the Regina area. "Communities" were identified through an extensive review of census data, social determinants of health, burden of disease and hospital use. Four health networks have been organized, each with their own unique elements to support the specific population of their defined geographic area.

Each network fosters a deep understanding of population health needs and available and appropriate health and community services, with an emphasis on high-quality transitions. Care services are shared and coordinated among a wide array of providers, including home care, primary health care, public health, treatment centres, community paramedicine, pharmacy services, house calls for older adults and specialty acute care. The qualities of a health network include the following:

- accountable
- support from birth to death
- responsive
- coordinated
- longitudinal (not episodic)

INTEGRATED SERVICE MODEL



Ref. Anderson, S & Comfort, P. Health Networks in Saskatchewan - Integrated Home Care and Primary Health Care: What Works?. 2018 PEI Home Care Summit PPT.

By engaging patients, caregivers and community members in the planning and development of services, health networks:

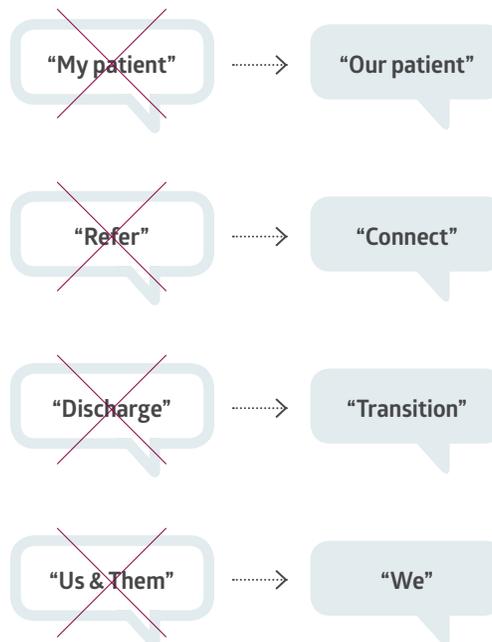
- recognize the relationship between physical, mental, social and spiritual well-being;
- consist of a wide range of coordinated services including prevention, health promotion, treatment and rehabilitation;
- provide care using a team approach;
- focus on better management and follow-up once a health problem has occurred;
- support prevention and management of chronic conditions;
- link with agencies and organizations to address other factors that influence health (e.g., housing, education, employment, income, social supports); and
- facilitate smooth transitions across all care settings (acute, long-term facility, home).

Tactically, the Regina area teams are:

- embracing a culture change and reframing patients as sharing patients;
- connecting rather than referring;
- using transitions instead of discharge;
- using a “we” attitude instead of “us and them”; and
- using team collaboration tools such as daily visual management overviews shared by all team members, purposeful huddles and leadership engagement.

Key success factors for the creation and sustainability of health networks are rigorous change management, trust, inclusion and engagement, face-to-face connections and shared goals to meet a common challenge. Barriers that continue to be addressed include communication challenges, technology and funding issues, and system organization (size and complexity).

CHANGE YOUR LANGUAGE, CHANGE YOUR CULTURE!



BRITISH COLUMBIA

Integrated Home Care and Primary Health Care: From Policy to Practice

Host:

ALISON KERNOGHAN–Research/Knowledge Exchange Associate, Geriatric Health Systems Research Group, Faculty of Applied Health Sciences, University of Waterloo

Guest Panelists:

KATHY CHOUNOR–Strategic Advisor, Seniors Services, BC Ministry of Health

LISA ZETES-ZANATTA–Executive Director, New Westminster and Tri-Cities Communities, Eagle Ridge Hospital, Centralized Home Health Services, Regional Home Health Network, Fraser Health Authority

Policy Direction

A new primary health care strategy has been launched across British Columbia with the goal of delivering faster and improved access to health care. The foundation of the approach is a focus on team-based care and connecting patients to appropriate care. This new policy direction builds on existing best practices across the province and emphasizes a broader and more comprehensive approach.

Primary Care Networks (PCNs) are the foundation of the integrated system of primary and community care and will link primary care providers and services within defined geographic areas. Through a team-based approach, these networks enable patients to access a full range of health care options, from maternity to end-of-life, by streamlining referrals across the health system. The networks are being rolled out in the first five communities: Burnaby, Comox, Prince George, Richmond and South Okanagan Similkameen. The networks will be implemented in at least 15 communities over the next 12 months, and across 70% of BC communities (with populations between 50,000 and 100,000 and smaller populations in rural areas) over the next three years.

Specialized Community Services Programs (SCSPs) are targeted services for individuals with complex medical challenges and older adults living with frailty (including individuals living with dementia). The goal of this program is to provide better coordinated care, reduce hospitalizations and increase the length of time older adults can safely and appropriately remain at home. The program has an efficient intake and assessment process to provide enhanced patient-centred supports, and actively works with PCNs to identify patients who need increased support. Comprehensive case management and coordination services are key functions. A comprehensive array of services includes, but is not limited to, community nursing and allied health services, home support, respite care, assisted living, long-term care, palliative care and chronic disease management.

Program design considerations include elements, expectations, linkages with PCNs, shared guidelines and partnerships with NGOs, legislation, regulations, service design, performance management and data collection strategies.

Team-based practices are enabled through:

- a population approach to program design;
- shared clinical pathways and protocols;
- a communication approach that emphasizes timely and appropriate response;
- service coordination across all settings of care;
- increased home support services and hours; and
- leveraging other health care professionals (e.g., paramedics) and technology to support this integrated model of care.

SCSPs will embrace:

- data collection and reporting that aligns with federal, provincial and regional requirements;
- flexibility for customization in metro, urban, rural and remote settings; and
- technology to support communication and information sharing.

Next steps:

- Collaborative services committees (i.e., representatives from local health authorities and family practice groups) are creating service plans outlining how they will develop their PCNs and SCSPs.
- Four communities have been approved and are starting PCN and SCSP implementation, with more communities coming online over the next few months.

SPECIALIZED COMMUNITY SERVICES PROGRAMS (SCSP) DESIGN

Partnership	Guideline	Process	Evaluation
<ul style="list-style-type: none">· Linkages to PCN's· Linkages to CBP/NGO's	<ul style="list-style-type: none">· Legislation· Regulations· Health Policy· Provincial directives	<ul style="list-style-type: none">· Local operations· Health authority level· Provincial	<ul style="list-style-type: none">· Performance measurement<ul style="list-style-type: none">-Provincial-National· Data collection<ul style="list-style-type: none">-Provincial-National

Practical Application

The Fraser Health Authority is a leader in taking policy to practice in the integration of home care and primary health care. Older adults living with frailty who live in Fraser Health communities receive coordinated, comprehensive support in their homes from nurses and teams as an extension of the care they receive from their family doctor or nurse practitioner. This transformational shift in primary care is enabled by the partnership between primary care and home care, facilitated by a primary care nurse.

First implemented in 2015, the program has evolved from a basic concept of allocating a “Nurse Debbie,” to supporting family physicians in the care of homebound older adults living with frailty. By working with “Nurse Debbie,” family physicians are able to direct and extend primary care services into patients’ homes to ensure they are quickly getting the care they need when a health issue emerges or before problems develop. The nurse provides hands-on care and case management, as well as coordination of community services.

With the success of the program and the provincial policy emphasis on integrated, team-based care, Fraser Health Authority has expanded its collaborative model to include PCNs and a broad range of community-based services, all coordinated through a primary care nurse. Acting as an integrator of health and social care services, primary care nurses embody team-based care. The enhanced program is expected to have a significant impact on preventing emergency room (ER) visits for a vulnerable population, in addition to health care cost savings.

ALBERTA

Integrated Home Care and Primary Health Care: Rural and Urban Models

Host:

ALISON KERNOGHAN – Research/Knowledge Exchange Associate, Geriatric Health Systems Research Group, Faculty of Applied Health Sciences, University of Waterloo

Guest Panelists:

AMY GOOD – Director, Integrated Home Care, Calgary Zone, Alberta Health Services

KIMBERLY NICKORIUK – Seniors Health Lead for Quality Initiatives and Program Planning, Central Zone, Alberta Health Services

Home Care and Primary Health Care – Rural Region

The Central Zone of Alberta Health Services interacts with 14 PCNs across a rural geographic region and has 32 home care offices that provide services to 9000 clients on a monthly basis. The key focus of all program enhancements in the Central Zone has been to recognize the geographical challenges and service disparity that impact both the quality of care and access to care. Access to home care services has been streamlined through a centralized call centre, with one access number for all continuing care services. Integrated care is achieved in the Central Zone through several different strategies.

The Community Support Team (Community Paramedic Program and Intensive Home Care Program) consists of evidence-informed, patient-centred and sustainable programs. These programs alleviate pressure on acute care facilities by decreasing hospital/ER visits and admissions and EMS transports, while supporting the needs and wishes of patients in continuing care.

- **Mobile Integrated Healthcare Community Paramedic Program** is designed to improve access to medical care for seniors and vulnerable and mobility-challenged people who require non-emergency medical attention. The program specializes in managing urgent and primary care events and bringing hospital care into the home. From a team-based care perspective, this program applies the paramedic scope of practice to non-emergent medical management. Community paramedics enhance the home care team, and through integration with primary health care, they can access physicians' orders that support the home care nurses' skills and enable patients to receive necessary medical care in their own homes.

COMMUNITY PARAMEDIC PROGRAM CALLS



- **Intensive Home Care and Community Support Team** provides home care and self-help services, along with access to and facilitation of senior-friendly housing and transportation. It also tackles social isolation. This program provides up to 24-hour support for complex clients needing additional resources until their complex health needs stabilize, additional resources to support discharge from hospital, and/or additional resources to wait at home until an alternate level of care is arranged.
- **Palliative Resource Nurse Program** and the recent addition of a nurse practitioner have provided more clients with the opportunity to receive holistic end-of-life services closer to home. Palliative clients can be supported in the setting of their choosing and receive pain and symptom management in a more timely and effective manner. Visits to ER for palliative clients in the CTAS 4 and 5 triage scale have been reduced by 25% over the course of the last year.

Home Care and Primary Health Care – Urban Region

The more urban Calgary Zone of Alberta Health Services provides home care service to 37,000 clients annually and manages up to 15,000 clients through an integrated home care program. Within the City of Calgary there are three Seniors Teams (geographically based), Adults Team, Palliative Home Care Team and other "specialty" teams. Of the clients in the Integrated Home Care Program (IHC), 92% have a primary care physician. These home care clients are attached to 3,655 unique primary care physicians. Seven PCNs are located in the Calgary Zone, four of which are within the City of Calgary.

Integrated Home Care: Physician Collaborative Team (PCT)

Responding to an identified need to integrate services between primary care networks and home care, the IHC Program was created to improve professional relationships and collaboration between family physicians and home care case managers. Through the investment of \$520,000 annually toward 3.0 full-time equivalent (FTE) case managers and 1.0 FTE care manager, the Physician Collaborative Team (PCT) achieved the following significant outcomes:

- Patients, physicians and staff agree that person-centred care was promoted as a result of this model.
- Clients felt that the home care case manager (HCCM) and physician worked together to coordinate their care and did not duplicate services.
- Physicians indicated it was easier to contact an HCCM to discuss an urgent client care matter and monitor patients' progress.
- Access to health care services was improved.
- Hospital length of stay was reduced by 22% three months after the client was transferred to the PCT.

“ I have a patient, who was frequently in and out of the hospital, who we have been able to manage better in the community and avoid hospitalizations.

-Physician



Based on the experiences and outcomes of the PCT, the following opportunities were identified:

- Communication and information sharing – The PCT case manager communicates by meeting monthly with primary care physicians to review client charts, enter information into client EMRs and use technology to communicate (e.g. phone and email).
- Skills and experience of Home Care Case Manager - primary care physicians emphasized the importance of how the HCCMs prioritize what they bring to the doctor's attention and the strength of their clinical, professional, and personal skills.
- Physician buy-in - primary care physicians must understand the value of the collaboration as they currently cannot bill for time spent meeting/discussing clients with the Home Care Case Manager.
- Inter-professional relationships - Home Care Case Managers and primary care physicians indicated that strong working relationships between them were vital to successful client care.
- Integration of Physician Collaborative Team Case Managers with the Integrated Home Care Program— Physician Collaborative Team Case Managers refer their clients to home care programs and services, therefore Physician Collaborative Team Case Managers need to be integrated with the home care program.

Seniors' Home-Based Primary Care (SHBPC) Demonstration Project

A multi-disciplinary primary care model that brings the patient's "medical home" to the home of frail, homebound older adults. This program was developed by the Calgary West Central Primary Care Network (CWC PCN) and Alberta Health Services (AHS) Home Care. Launched in April 2017, this demonstration project had a capacity for 24 active patients. The program was specifically designed to provide comprehensive care for medically-complex older adults with multiple co-morbidities who, for reasons of physical, emotional or social frailty, cannot otherwise access clinic-based care. SHBPC assists these individuals with their goals of maintaining their independence and reducing preventable ER visits and hospitalizations.

The in-home delivery of comprehensive, longitudinal primary care by an interdisciplinary team not only brings the "medical home" to the patient's home, it also allows the patient to age-in-place with respect, dignity and comfort. Clients seen by the SHBPC team must be unable to access their/a family physician due to cognitive, physical or social frailty and must require home-based care.

Pilot evaluation and outcomes include the following:

- Of the clients referred to the initiative, 66% were accepted; the remaining did not meet criteria or declined.
- The Assessment of Inter-Professional Team Collaborative Scale (AITCS) II6 was used to measure whether the core team was working in an integrated manner. This validated instrument has been used extensively in health care and measures three constructs: partnership, cooperation and collaboration.
- While some aspects of these constructs improved one year after implementation, the overall scores suggested the team was less collaborative than in the previous year.
- Most importantly, listening to the wishes of their clients when determining the process of care chosen by the team did improve with the initiative.

ONTARIO

Integrated Home Care and Primary Health Care: Embedding Care Coordination in Primary Care

Host:

ALISON KERNOGHAN—Research/Knowledge Exchange Associate, Geriatric Health Systems Research Group, Faculty of Applied Health Sciences, University of Waterloo

Guest Panelist:

MARTINA ROZSA—Vice President, Home and Community Care, Hamilton Niagara Haldimand Brant, Local Health Integration Network, Ontario

Embedding Care Coordination in Primary Care—Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN)

Across Ontario, the 2017–2018 mandate letter to Local Health Integration Networks (LHINs) identified as a priority the need to “develop and implement a plan with input from primary care providers, patients, family caregivers and partners that embeds care coordinators and system navigators in primary care to ensure smooth transitions between home and community care and other health and social services as required.” Embedding care coordination in primary care continues to be a priority for LHINs in 2018–2019 as a key enabler in health system improvements and improving the patient experience.

Locally across the HNHB LHIN region, patients receiving care identified several common issues:

- inability or difficulty to get connected to a primary care physician;
- difficult transitions across sectors (e.g., hospital to home);
- need to tell and re-tell their stories;
- little to no information to support patients in decision-making regarding their care options;
- falling through the cracks; and
- fragmentation between sectors (e.g., hospital, mental health, social services).

To support the provincial directive and response to community needs, the HNHB LHIN sub-regions assumed a lead role in integrating primary care with home and community care. The LHINs worked closely with primary care providers to plan services, undertake health human resource planning, improve access to inter-professional teams and link patients with primary care services. Home care coordinators were deployed into community settings, such as community health centres, family health teams and hospitals.

Guided by a set of core principles and leveraging existing resources and expertise, the goals of the integrated approach in the HNHB LHIN were to:

- embed care coordinators and system navigators in primary care settings to ensure smooth transitions of care between home and community care and other health and social services as required; and
- strengthen connections between care coordinators and primary care teams.

A FRAMEWORK TO STRENGTHEN THE CONNECTION

	Level 1	Level 2	Level 3	Level 4	Level 5
Contact with primary care	Via phone	Via phone	Via phone	Via phone and in person	Via phone and in person
Primary care interest and willingness to initiate partnership	None	Some willingness to partner when needed	Potential to evolve into stronger connection	Open agreement to partner regularly	Embrace partnership fully and collaborate to strengthen working relationship
Sharing of information	None	Limited (via phone and email)	Limited (via phone and email)	Regularly in person and virtually	Formalized with access to patient record systems

The HNHBLHIN is taking a phased approach to embed care coordination in primary care:

- Phase 1 targets Community Health Centres (CHCs) and Aboriginal Health Access Centres (AHAC).
- Phase 2 focuses on Family Health Teams and larger Family Health Organizations.
- Phase 3 will include all other primary care not implemented in phase 1 or 2 (e.g., solo practices, other family health groups).

Phase 1: CHCs and AHACs

The HNHBLHIN leveraged existing relationships with leadership at CHCs and AHACs through a collaborative development model to create a joint integration strategy. LHIN and CHC/AHAC leadership co-developed the following key components of the strategy:

- Vision – established jointly between sub-region directors (Health System Strategy and Integration) and CHC/AHAC executive directors.
- Operational strategy and approach – developed in partnership between patient care directors (home and community care) and CHC/AHAC, in consultation with sub-region directors.
- Operational logistics and implementation – in development through partnership between patient care managers (home and community care) and CHC/AHAC, with care coordinators being introduced to CHC/AHAC in September 2018 and actively participating in the development of operational model implementation.

Joint education/orientation – LHIN and CHCs/AHACs will partner to ensure that all primary care providers, allied health and care coordinators have a common understanding of the goals, objectives and partnership required to be successful. The foundational elements to influence a partnership in terms of how LHINs will work differently with primary care are being emphasized to support achieving a common understanding. The foundational elements identified by both CHCs/AHACs and LHINs include:

- the mandate, role and function of care coordination teams (care coordinator and patient care assistant) in assessing, authorizing and monitoring contracted service provision, long-term care eligibility and processes, and relevant legislation;
- the mandate of, population served by and operational model of CHCs; and
- opportunity to tailor orientation/education specific to the CHC and AHAC team composition, number of patients served, programs and services, etc.

MANITOBA

Integrated Home Care and Primary Health Care: Silos to Integration

Host:

ALISON KERNOGHAN – Research/Knowledge Exchange Associate, Geriatric Health Systems Research Group, Faculty of Applied Health Sciences, University of Waterloo

Guest Panelist:

VIKAS SETHI – Executive Director, Integrated Primary and Home Health Service, Winnipeg Regional Health Authority, Manitoba

Silos To Integration: A Process Continuum

In Manitoba, primary care is building on numerous successful initiatives to support the development and enhancement of two underpinning components: home clinics and My Health Teams. These two integral elements are currently in the development/implementation stages and will work together to provide a health care foundation and health care neighbourhood/network for individuals across Manitoba. The goal of this integrated approach is reliable access, coordination and continuity of care for patients.

Home clinics are primary care clinics that provide patients with timely access to care, coordinate care and manage health care records. Patients select family physicians or nurse practitioners as their main primary care provider. My Health Teams are teams of care providers (either co-located or virtually connected) that work together to plan and deliver services for a geographic area or specific community or population. The teams are comprised of health professions and resources from public health, community mental health, home care and long-term care/healthy aging.

Integrated Care – A Strategic Initiative in Winnipeg Regional Health Authority

In alignment with provincial health goals, the Winnipeg Regional Health Authority's (WRHA) 2016–2021 strategic directions include a targeted focus on improving quality and integration to provide care for all in an accessible manner. This priority is translated into operational strategies to “improve patient flow.”

Several actions specifically address integration, team-based care and the goal to “deliver the right health care, in the right place, and at the right time”:

- Advocate for and enable staffing models for service delivery seven days a week in all sectors.
- Explore new models of enhancing health service delivery to older adults.
- Further integrate programs and service areas within and between health sectors (e.g., chronic disease, care of older adults, the journey of patients with cancer, priority populations, mental health and maternal/child health), and improve care between transition points.
- Identify strategies, collaborations and other approaches that will improve health equity and the consequential use of the health care system, including an emphasis on health promotion strategies.

Building on the home clinics and My Health Team mandates, the WRHA's goal is that every primary care home clinic (PCHC) in Winnipeg will be connected to a single-point person in home care to enable partnerships, build stronger relationships, improve communications and help with community services navigation.

To achieve this goal, the WRHA will target PCHCs participating in the Winnipeg My Health Teams to ensure an understanding of a variety of practice styles and to leverage existing relationships. A pilot initiative commenced with one private fee for service clinic with a Primary Care Registered Nurse as the clinic contact and one Home Care Case Coordinator (HCCC). Outcomes of this work include:

- Minimal extra work for HCCC.
- Very positive experience with both RN and HCCC about the approach and benefits.
- RNs appreciated the responsiveness – did not have to wait on the phone; could leave a message and get a response.
- Having a consistent Home Care point person made communication easier and efficient.
- This approach helped build relationships with Home Care Case Coordinators and provides constructive and creative care planning conversations and service option discussions.

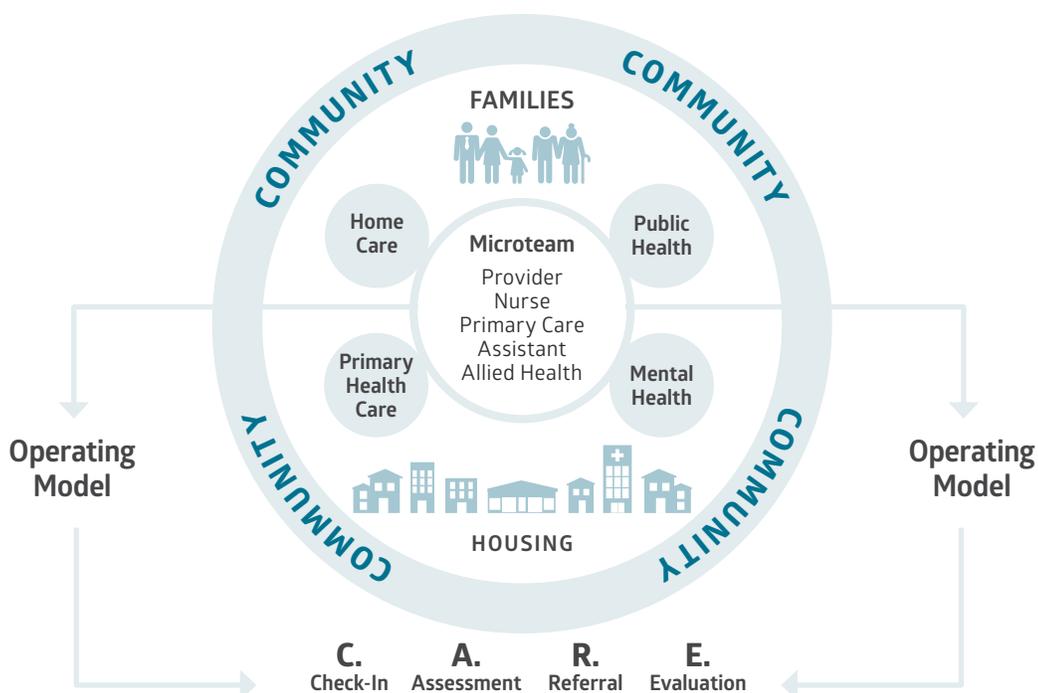
Micro Team-Based C.A.R.E. Model

A relationship-centred, team-based, integrative service delivery model is being developed and deployed in the WRHA area. Key components of this strategy include:

- A core team of primary care resources (primary care assistants, primary care nurses, nurse practitioners and physicians) that a service recipient considers their home base for primary care.
- Positioning the patient as the captain of their team and service providers are coaches.
- Using the C.A.R.E. process - check-in, assessment, referral, evaluation.

Micro-teams help link, connect, or navigate other health, social services or housing support (Macro Team). Health and Social Services in the community area are becoming better integrated by prioritizing services and supporting communication. Throughout this transformation, change management is a critical element. Designated change agents are provided time to develop relationships with new team members. Clarity of roles and responsibilities within the new team is essential and team members are encouraged to recognize and use their full scope of practice. Measurement and evaluation are currently underway through provider and clinician focus groups and the tracking of key measures and metrics including team-based performance indicators under review.

COMMUNITY AREA INTEGRATED PRIMARY HEALTH HUB





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Advancing Excellence in Home Care

