Alberta Health Services: Central Zone
Continuing Care

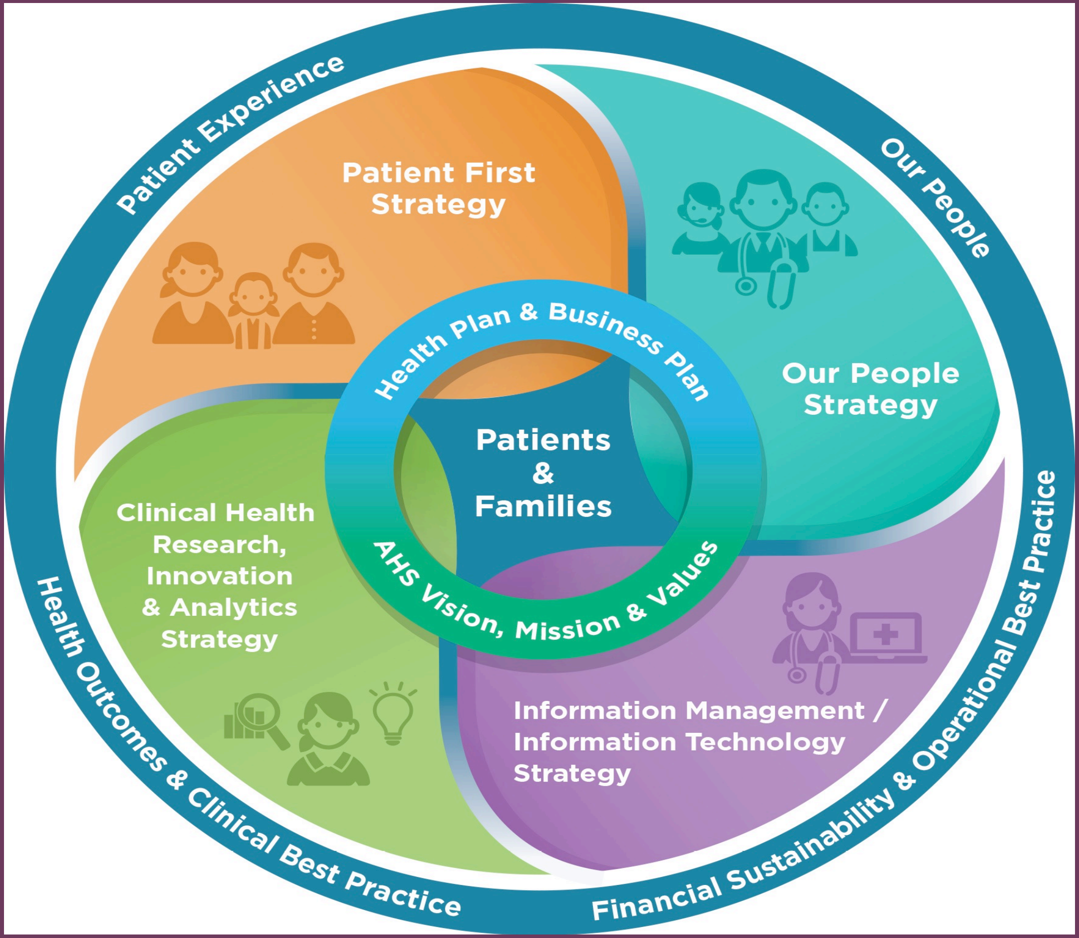
Integrated Home Care and Primary Health Care: Rural and Urban Models

Alberta Health Services

Alberta's philosophy for health and healthcare is an approach that emphasizes staying healthy and well, while also supporting people who need care. Their goal is a health system that provides the RIGHT care in the RIGHT place, at the RIGHT time, by the RIGHT health professionals, with the RIGHT information. Within this framework, the importance of integrated home care and primary care models is reinforced both in rural and urban areas. This presentation will share experience from both the rural and urban location and aims to provide insights into the essential elements of successful integrated models that deliver the right care at the right time in the right place.

So who decides what is right?

Integrated Home Care and Primary Care
Rural and Urban Models



https://www.albertahealthservices.ca/about/Page12951.aspx

Alberta Health Services

Alberta Health Services:
Central Zone

Central Zone Rural Model

Alberta Health Services

Integrated Home Care and Primary Care
Rural and Urban Models

Primary Care

Home Care

Case Management

Mobile Health Units

Strategic Clinical Networks

Patient First Strategy

Elder Friendly Care

Collaborative Care Design

Geriatric Specialist Team

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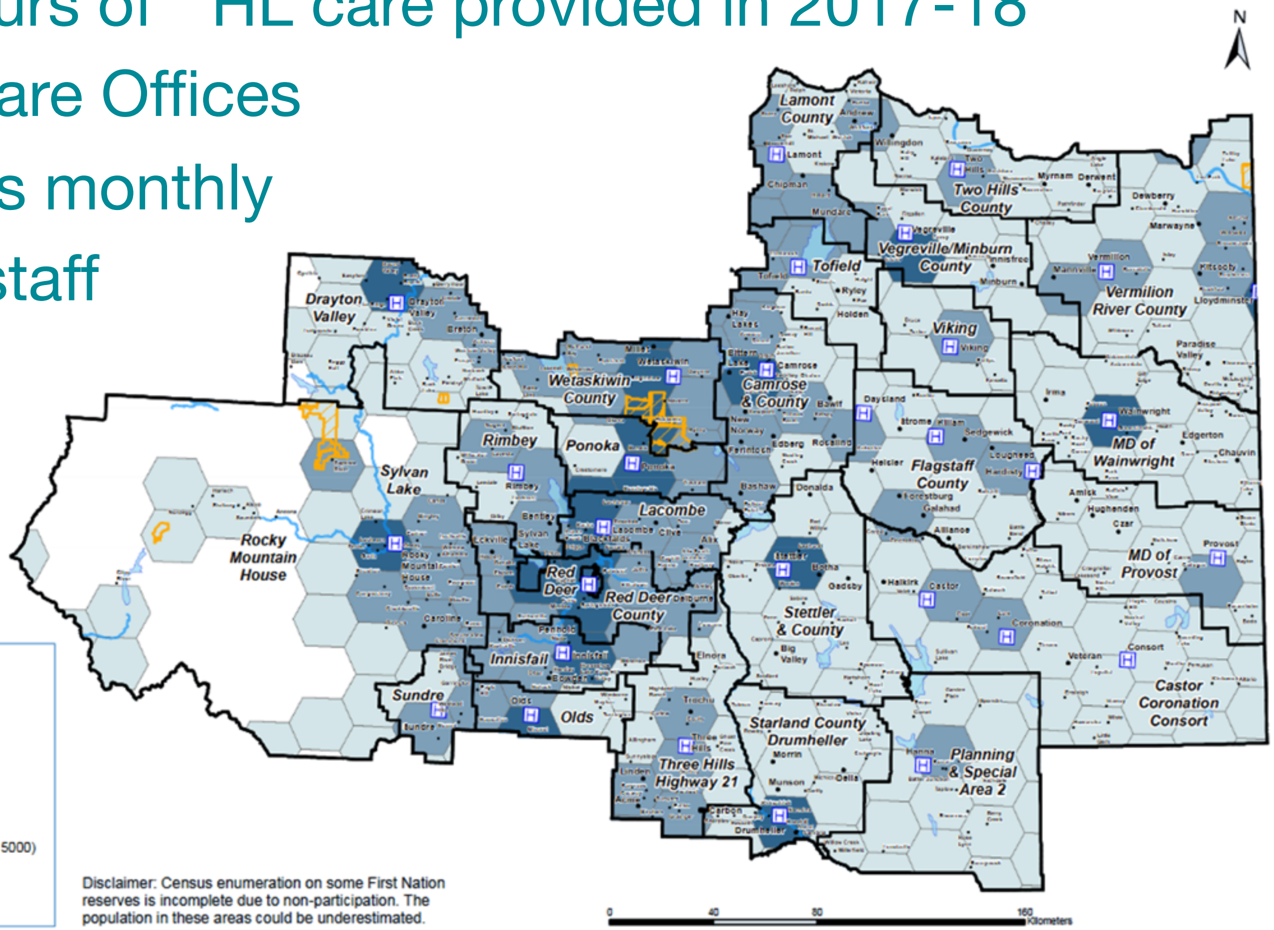
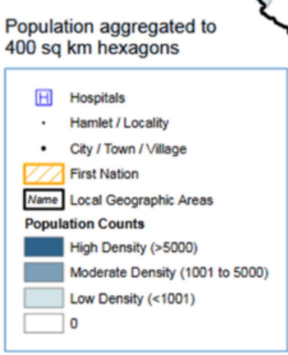
789,091 hours of *HL care provided in 2017-18

32 Home Care Offices

9000 Clients monthly

1023 AHS staff





14 Primary Care Networks (PCNS)

- Provost
- Big Country
- Drayton Valley
- Kalyna
- Lloydminster
- Peaks to Prairies
- Camrose
- Red Deer
- Rocky Mountain House
- Wainwright
- Wetaskiwin
- Wolf Creek
- *AB Heartland (EZ)*
- *Lakeland (NZ)*

- Central Zone Population - 404,308
- 78% of residents report having a family doctor
- 12% of the population over the age of 65

Inpatient

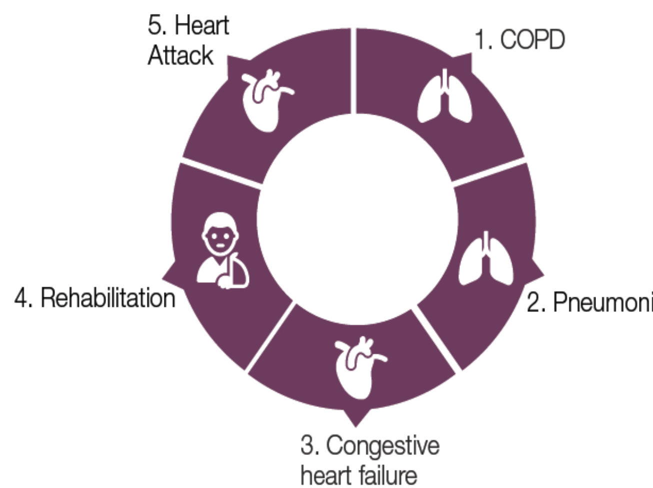
43,982
Hospital Discharges
AB: 301,334

328,939
Hospital Days
AB: 2,135,306

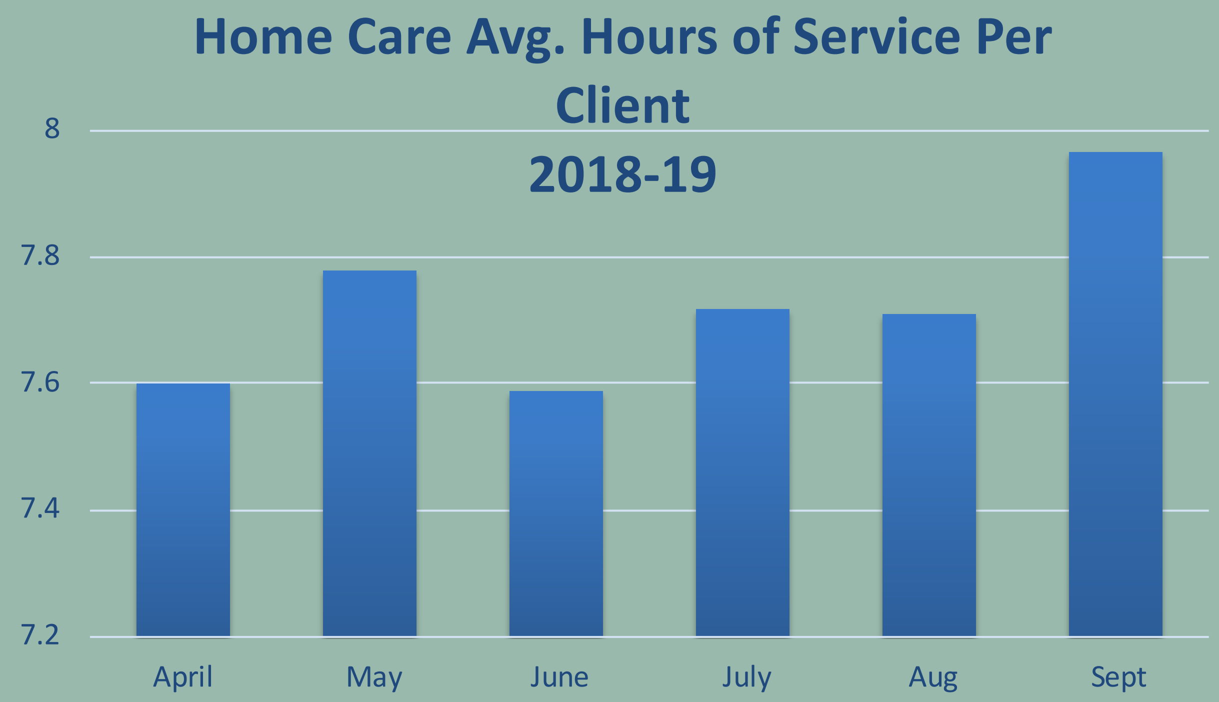
7.5
Average Length of Stay (in days)
AB: 7.1

1,102
Acute Care beds
AB: 8,452

Most Common Reasons for Hospitalizations
(excludes obstetric related causes and convalescence following surgery)



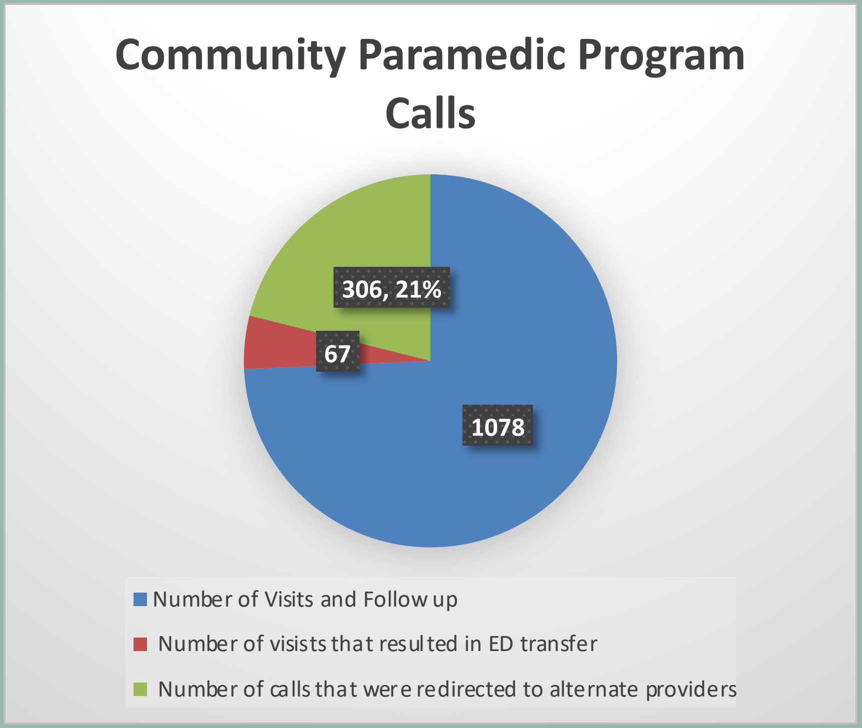
Monitoring Outcomes



**Only 8% of Caregivers report Distress (RAI-HC)

Mobile Integrated Healthcare – Community Paramedic Program

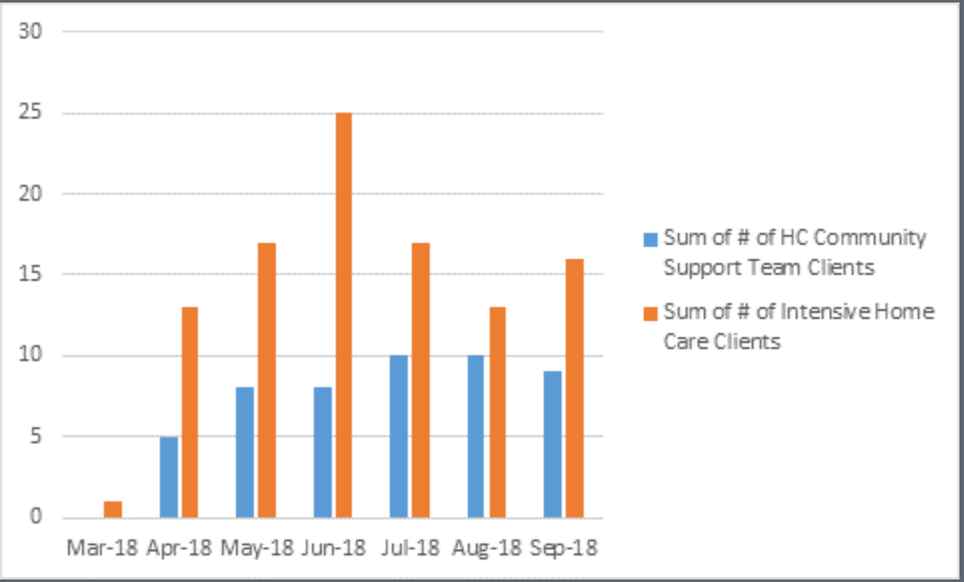
- Reduces Emergency Room visits
- Collaborates with Home care and Primary Care
- Provides the right care in the right place
- Supports patient autonomy and advanced care planning



Integrated Home Care and Primary Care
Rural and Urban Models

Intensive Home Care and Community Support Team

- ➢ Support early discharge from hospital
- ➢ Provide additional services for clients waiting ALC at home
- ➢ Coordinate care for complex and sub-acute clients



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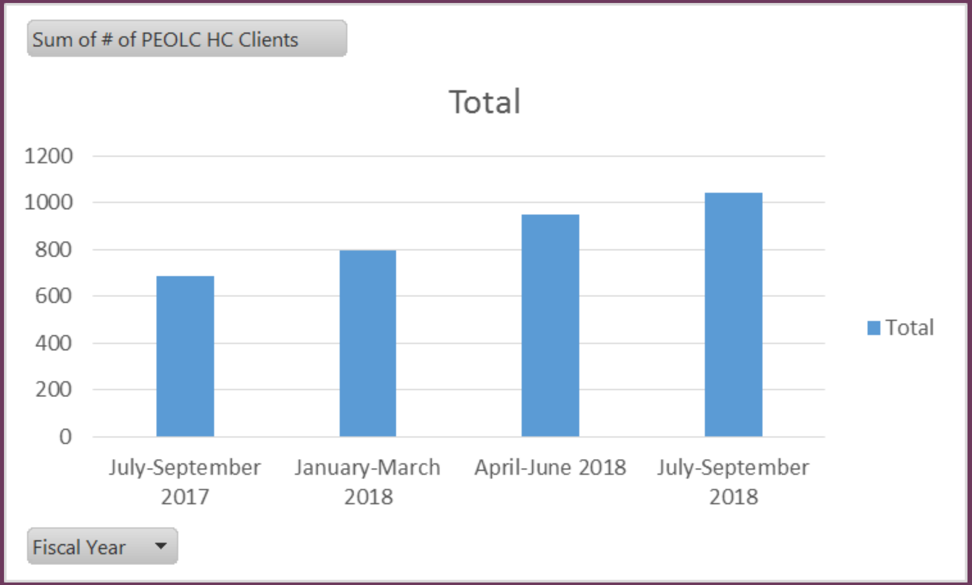
Palliative Resource Nurse Program – Central Zone

- Supports clients at End-of Life to provide the right care in the right place
- Recognizes client choice and supports Advanced Care Planning
- Provides resource and education services to all care streams



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Nurse Practitioners –

- Integration into the Interdisciplinary Team

Points of Consideration:

- ✓ System Integration
- ✓ Clarity of Purpose
- ✓ Develop Framework
- ✓ Maintain Relationships/Communication

Integrated Home Care and Primary Care
Rural and Urban Models

Access

Referral

Resource

Service Availability

Alberta Health Services:
Integrated Home Care, Calgary Zone

Calgary Zone Urban Model

Alberta Health Services

Integrated Home Care and Primary Care
Rural and Urban Models

Calgary Zone

- Population 1,634,393
- 83% had access to a family doctor

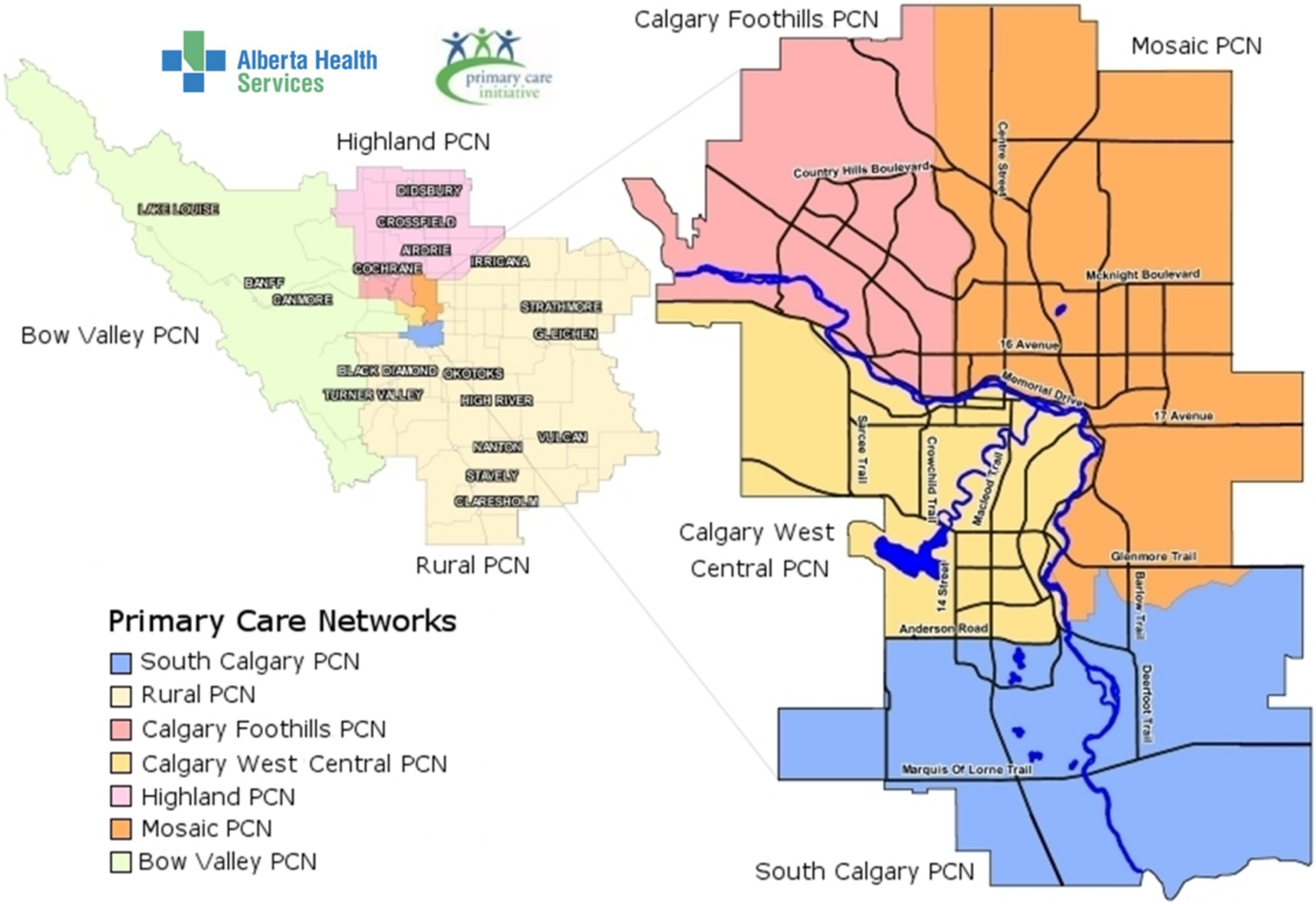
Integrated Home Care

- 37,000+ clients annually
- 773 FTE Professional Staff
- 3 Geographically based Seniors Teams, Adults Team, Palliative Home Care Team and other "specialty" teams
- 4.765M hours of service delivered annually

Primary Care

- 92% of Home Care clients had a primary care physician
- Home Care clients attached to 3,655 unique primary care physicians

Integrated Home Care and Primary Care
Urban and Rural Models



Integrated Home Care: Physician Collaborative Team

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

-Physician

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Physician Collaborative Team

The opportunity:

To improve professional relationships and collaboration between family physicians and home care case manager.

The Investment:

- *3.0 FTE Case Managers*
- *1.0 FTE Care Manager*

The Outcome:

- *Person centered care*
- *Improved access to Home Care resources*
- *Reduced acute care utilization*

Physician Collaborative Team: Sustain & Spread

Opportunities:

- Communication
- Skills & Experience of Home Care Case Manager
- Physician Buy-In
- Inter-professional Relationships
- Integration of PCT Case Manager with Integrated Home Care Program

Barriers:

- Scale and Spread to all of home care and all PCN offices
- Requires a strategic Zone wide approach with multiple stakeholders

Integrated Home Care:

Seniors Home Based Primary Care

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Seniors Home Based Primary Care

The opportunity:

To pilot a home-based primary care model that meets patient, caregiver, and provider needs.

The Investment:

- *0.2 FTE Physician*
- *0.5 FTE Home Care Case Manager*
- *0.2 FTE GCN*
- *01 FTE Pharmacists*
- *0.4 FTE LPN*
- *0.2 FTE MOA*

The Outcome:

- *66% of clients accepted*
- *Opportunity to improve collaboration*
- *Person Centered Care*

Integrated Home Care: Integrated Home Care Design Day

Integrated Home Care: Design Day

Complex Client Collaboration

Bow Corridor PCN Collaboration

Physician Collaborative Team

Joint PCN & HC Client Lists Reviews

The West Bow Collaborative

Peter Coyle Place Harm Reduction Model

Geriatric Consult Team

PCN Pharmacists Partnership

Partners for Better Health

Seniors Home Based Primary Care

Collaborative Case Conferencing

Physician Notification Project

The Opportunity!

Points of Consideration for Program Development

- ✓ Not a one size fits all approach

Alberta Health Services

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