Vision 2020

November 14th, Concurrent Session 3, 11am
HOW DO WE INTEGRATE THE MEDICAL MODEL OF HEALTHCARE WITH COMMUNITY-BASED SOCIAL SERVICES?

• Lawrence Braul, Trinity Place Foundation of Alberta
• Carol Anderson, Continuing Care, Edmonton Zone, Alberta Health Services
• Carol Carifelle-Brzezicki, North Population, Public and Indigenous Health, Indigenous Health Program
• Karen McDonald, Sage Seniors Association
EXAMPLES OF INTEGRATED MODELS OF SERVICE DELIVERY

WHAT WORKED WELL AND WHAT WAS CHALLENGING

PROMISING PRACTICE

INSIGHTS AND LEARNINGS
HOW DO WE INTEGRATE THE MEDICAL MODEL OF HEALTHCARE WITH COMMUNITY-BASED SOCIAL SERVICES?

Lawrence Braul
Trinity Place Foundation of Alberta
Peter Coyle Place - Approach

• Housing First, congregate living, 70 units
• Opened in June 2005
• Harm reduction philosophy of care
• Compassionate staff
• Residents encouraged to treat PCP as their permanent home
• 20 dormitory style beds in small 3-5 person dorms
• 50 individual units (225 square feet)
Peter Coyle Place
Referral Sources & Criteria

• Acute care facilities (27%)
• Health care professionals (28%)
• Emergency shelter (24%)
• Other agencies (21%)
• No further housing options in the community
• Homeless or at imminent risk of homelessness
• Chronic mental illness &/or addiction issues
Peter Coyle Place - Residents

- Age: average 61 yrs (range 54 – 86yrs)
- Gender: male (n=59, 71%), female (n=24, 29%)
- Ethnicity: Caucasian (n=76, 92%) Indigenous (4), Jewish (2), African/Caribbean descent (1)
- Language: English, born in Canada (n=80/83)
- Marital status: all single at time of admission
- Acuity on Admission: 92% “High” or “Very High”
- Average Length of stay: 4 yrs (longest 11yrs)
Peter Coyle Place - Outcomes

<table>
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<tr>
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<th>Prior to Admission to PCP (1 year)</th>
<th>While living at PCP (9 months)</th>
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<tbody>
<tr>
<td>Aggregate days in hospital</td>
<td>864 days</td>
<td>84 days</td>
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<tr>
<td>Average length of stay</td>
<td>124 days</td>
<td>7 days or less</td>
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No significant reduction in EMS usage, possibly due to overall frailty (similar to other studies)

(Hoffart I. and K. Cairns 2016 p.32)
What has worked Well?

• A gradual acceptance of the cost/benefit of permanent supportive housing. PCP was funded as a shelter for the first ten years and is still not adequately funded as a supportive care facility.

• Academic research examining the social determinants of health have validated the importance of poverty reduction, safe housing, access to health care, social connections with family and friends.

• Other examples have begun to emerge – ie. Ambrose Place in Edmonton with strong empirical evidence to support the investment that these facilities require.

• A growing appreciation that these facilities thrive when there is a community of care that involves staff, residents, and visiting health professionals.

• A growing appreciation of the value of empathy, acceptance, and kindness in the day to day lives of all who work at or live at the facility. It is a kind environment.

• Currently a site for the research of Dr. Lara Nixon funded by CMHC and the Federal Department of Health to provide funds to “scale up” the resources that are available.
What has been difficult

• Under funded considering the complexity of the residents
• Increasing service standards and certification requirements under Alberta Supportive Living Accommodation Act
• Initially, it was impossible to get the Health Care system to buy in and support the facility and provide resources such as on site Home Care, Personal Care, Physician care.
Future opportunities to work more closely with health care professionals

• Starting construction of the 70 unit Templemont facility, based upon the harm reduction philosophy of care.
• Funded by AHS Continuing Care as an SL4 “Special Population”
• Completion will be in 2021.
• Will build on the research of Dr. Lara Nixon and other successful programs in Canada that provide supports to marginalized populations.
• The Peter Coyle Place approach to care and treatment is going mainstream because there is evidence that it is effective in enhancing quality of life of persons who are otherwise untreated and often languish in hospital.
• Dr. Sandy Buchman, President of the Canadian Medical Association says, “50% of our health is derived from the Social determinants including such things as stable safe housing, access to health care, adequate support.
• “Poverty kills”
• “Homelessness kills” The average life expectancy of a homeless person is 45 years old.
• “The Opioid Crisis kills 4500 Canadians every year. This is like a fully loaded jet liner crashing every month in Canada with complete loss of life.”
• The homeless population is aging.
• We can and must do better.
• We can achieve remarkable outcomes by working together with Health Care colleagues rather than working in our respective silos.
HEALTHCARE/BCSS PANEL DISCUSSION

Vision 2030
November 14, 2019

Carol Anderson
Executive Director, Continuing Care, Edmonton Zone
Alberta Health Services
Enhancing Care in the Community

GOAL: To shift from providing care in a hospital setting to providing care in the community.

RESULT: Taking pressure off Emergency Departments and making beds available to those who need them.
PARTNERSHIPS BETWEEN HEALTH SYSTEM AND COMMUNITY BASED SERVICE PROVIDERS

Enhancing Care in the Community (ECC)

- Provincially $125M was provided:
  - Targeted to frail and at risk elderly in the community;
  - Enhance community services to avoid unnecessary acute care utilization;
  - Optimize Home Care and avoid unnecessary placement in SL and LTC
- Edmonton Zone received $25.0M from ECC
Invoicing

- Expanded self managed care options in the Edmonton Zone:
  - Less administratively burdensome for clients and AHS;
  - Empowers clients and families;
  - Enables choice;
  - Supports situations where consistency, cultural alignment and relationships are key to service delivery

- Clients/family service needs are assessed and hours assigned for personal care, respite or homemaking
- Clients/families choose their provider, AHS approves and invoices are reimbursed monthly
- Approximately 300+ clients are accessing and it continues to grow.
BENEFITS OF INTEGRATION INCLUDE IMPROVED PHYSICAL & MENTAL HEALTH, ENHANCED SOCIAL AND COMMUNITY CONNECTIONS

Home Living Supports

- The success of Destination Home means more clients are remaining in the community;
- Edmonton Zone wanted to pilot the potential for enhancing Home Care support services:
  - Caregiver respite
  - IADL supports
- Enhanced respite services and Independent Support Packages (for IADLs) were tested by 4 pilot teams (urban, inner city, suburban, rural)
- Evaluation results are being collated.
E4C Financial Management Program

- AHS has contracted with E4C, an Edmonton non-profit agency, to provide financial management services including in-trust accounts, bill payments, benefit access, income tax support, etc., to 80 Continuing Care clients who struggle with money management and desired support.
- Formal trusteeship requests to the Office of the Public Trustee can take 12-18 months to process often resulting in clients remaining in acute care or transition units; the E4C program permits clients to move forward in a much timelier manner.
HOW DO WE INTEGRATE THE MEDICAL MODEL OF HEALTHCARE WITH COMMUNITY-BASED SOCIAL SERVICES?

Carol Carifelle-Brzezicki,
North Population, Public and Indigenous Health, Indigenous Health Program
Territorial acknowledgement

“We (I) would like to acknowledge that we are gathered today on Treaty 6 Territory and the Metis Nation of Alberta Region 4 - this is their/our traditional meeting place and home for many Indigenous peoples including the Cree (“Cree”), Anishinabe (Ah-nish-in-ah-BAY), Blackfoot, Stoney Nakota (“Stoh-knee Na-ko-ta”), Dene (“Den-nay”), Inuit (“In-yoo-it”) and the Métis (“May-TEE”) peoples.
Wisdom Council

• Provincial Advisory Council that reports directly to AHS CEO
• Currently there are 20 Wisdom Council members
  o 8 of which are a part of the Elder’s circle
• Membership consists of a mixed representation across Alberta
  o Includes, First Nation, Metis and Inuit representation
  o Elder, Youth and Health professional
  o Urban, Rural, On-Off Reserve and settlements
  o North, Edmonton, Central, Calgary and South Zones
• Membership is based on a 3 year team, renewal of term can be made up to a maximum 2 years, with Elder representation to be reviewed through traditional lens
ARP- Indigenous Physicians

Primary Care Access - Indigenous Wellness Program – Clinical Alternate Relationship Plan (ARP) ending March 31, 2019 is 18.24 Full Time Equivalents (FTES)

Including 41 physicians: 33 General Practitioners, 2 Endocrinologists, 1 Internal Medicine, 2 Obstetrician-gynecologists, 2 Pediatricians & 1 Psychiatrist

Physicians are located at the following sites:

Indigenous Wellness Clinic and Poundmakers Lodge, Edmonton.
Elbow River Healing Lodge, Calgary.

• Patient visits including direct and indirect care are 56,071.
• Unattended appointments at 25.5 %, due to no-shows, cancellations and re-bookings.
Supports available to Indigenous patients (seniors/Elders) who attend the Indigenous Wellness clinic

- Mental health and Addictions cultural Helper
- Indigenous Health Coordinator
- Indigenous Cultural Helpers (First Nation, Metis and Inuit) – most speak their traditional language and practice their culture
- Dietician - who worked ten years in a mobile capacity in communities in northern Alberta.
- Physiotherapist
- Physicians, RNs, LPNs and Administrative Support who are either Indigenous or they have spent a tremendous amount of time in Indigenous communities.
Aging well: providing opportunity to practice traditional forms of practices: Music Therapy, medicine picking & sweats
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Karen McDonald,
Sage Seniors Association
MODEL
Community-based NP-led Primary Care integrated into existing social services and recreational programming

APPROACH
Patient-centred care Wrap-around support

POPULATION
Low-resourced older adults

CLIENT STORY
S U C C E S S E S

• Right provider at the right time
• Patient centered
• Partnerships
• Patient satisfaction
CHALLENGES

• Funding stability
• NP recruitment and client education
• Valuing social outcomes
• Information sharing/database integration
PROMISING PRACTICE

- 66% of patients are accessing both clinical and non-clinical services
- 61% increase in unique social work and life enrichment participants
- Frailty/ resiliency screening
  - Canadian Foundation for Healthcare Improvement Project
- Social prescribing
- Organizational outcomes evaluation framework
Common themes that emerged between the initiatives.
Possibilities and opportunities in working toward Vision 2030.