Long Range Planning

Calgary Zone Highlights

Albertans, community health partners, Alberta Health Services (AHS) and Alberta Health are working together to plan the future of healthcare in our communities. Community engagement on planning began in September 2016 with workshops, think tanks and other meetings with Albertans to start visioning for healthcare delivery out to 2031. A working session was held March 15 to get feedback on some of the work underway.

Scope of March Calgary Zone planning session

- **133** people participated
- Fast paced, interactive day-long session
- **14** health delivery options presented
- Strengths, challenges, and questions gathered for each option
- **1,381** distinct pieces of feedback provided by participants

The big question

What health system options, or attributes within them, could be considered or built on to co-design and co-deliver a transformation of care into the community?

The intent of the day

To understand which of the presented healthcare delivery options were seen as being most likely to be successful in transforming care.

Feedback

The following ideas were seen by participants as being most helpful in transforming care into the community:

Alberta Health Services

Long Range Planning

What We Heard Summary Calgary Zone

About long range planning

Albertans, community health partners, Alberta Health Services (AHS) and Alberta Health are working together to plan the future of healthcare in our communities. The goal is to co-design a sustainable, quality health system that promotes healthy communities and provides access to services, programs and facilities across the province. By working together, we can explore new, innovative ways of delivering care and preventing illness and injury. Community participation in the planning process began in September 2016 with workshops, think tanks and other meetings with Albertans to start visioning for healthcare delivery out to 2031. For more information about the November/December sessions, see the 'What We Heard' reports on AHS' long range planning blog.

About the March session

In March, a planning session was held in Calgary Zone. Participants included community members, healthcare providers, Alberta Health Services, and Alberta Health.

The session was an opportunity to give feedback on some of the work underway, and is just one of many inputs into the overall planning process. At the same time, Alberta Health and AHS continue to focus on current and emerging healthcare priorities.

There were many useful and valuable comments from the session. This summary provides a sampling of comments from the Calgary planning session.

What was shared at the session

Health experts from across AHS reviewed the many comments that came out of the fall sessions, and worked on developing and/or evaluating healthcare delivery options that would:

- be best suited to help meet the vision that was identified through fall sessions: transforming care into the community
- best support and deliver better patient outcomes in one or all of the three key priority areas identified after the fall engagement sessions
    - healthy aging and senior's health
    - addiction and mental health
    - focus on community (Primary Health Care, Public Health, Prevention)
- reflect best practices and innovations locally and from around the world that improve patient outcomes by keeping care closer to home

Alberta Health Services

Approach to the session

Fourteen health delivery options were presented by health experts. In planning of the delivery options to be presented, consideration was given to continued growth of Alberta's population, increased health need, potential for 'demand' to outstrip 'supply', limited future resources, commitment to 'care closer to home' – building capacity and capability outside of hospitals

- more than 130 participants came together and reviewed the options
- participants provided thoughts on strengths, challenges, and asked questions regarding each option.
- the goal was to gather feedback on various options that are being evaluated for transforming care into the community
- the healthcare delivery options presented reflect a sampling of the many inputs that will be considered in the zone long range plan; other analysis continues, and progress will be shared at project milestones

Principles, values and considerations

While participants gave specific feedback on all of the options presented (summary provided in the following pages), many provided guidance and ideas on the principles and values that we need to continue to be mindful of as we plan how to transform care into the community. Some of the considerations important to many participants included healthcare that:

- empowers individuals and communities, and involves caregivers and family
- encourages patient accountability and appropriate use of services
- supports patients to have access to the health system and services, and ensures the system is easier for them to navigate
- incorporates partnership and integration of a variety of caregivers
- respects different cultures
- reflects consideration for funding/workforce/infrastructure, etc.
- incorporates prevention, education and early intervention

Calgary Zone participants

Participants in the March session were selected based on their knowledge and experience in the topics being presented. The session was meant as a touch point for feedback from a diverse representation of stakeholders. Participants included post-secondary, non-profits, health partners, Primary Care Networks (PCNs), Home Care providers, Alberta Health, AHS, and other care providers and operators, and more.

Category	Attendees
AHS	• Leadership from various departments and programs throughout AHS' Calgary Zone and from across provincial service programs.
Key partner representation	• The Alex • Calgary Homeless Foundation • Palix Foundation
Health community representation	• Physicians and clinical community • EMS • East Calgary Family Care Clinic • Primary Care Networks • Strategic Clinical Networks and provincial programs
Health partners	• Covenant Health • AHS and contracted care providers • Home Care and Continuing Care partners • Calgary Lab Services • Prairie Mountain Health Advisory Council • Cancer Provincial Advisory Council • Addiction and Mental Health Provincial Advisory Council • Patient and Family advisors • Imagine Citizens • Community members
Government	• Government of Alberta • Alberta Health (also co-leads on the planning work)
Academic	• Physician Learning Program, University of Calgary • Cumming School of Medicine, University of Calgary • Faculty of Nursing, University of Calgary

Summary of feedback by presentation

Detailed feedback from participants was provided to the teams that worked on each healthcare delivery option.

Medical Home description: would improve health outcomes by providing a patient, family, and community centered approach to integrated health service planning and delivery that spans a comprehensive and coordinated continuum of care. The continuum includes primary, secondary, tertiary, and specialty care, as well as, community and social service supports.

Summary of feedback		
Why participants liked the option	**Challenges noted**	**Questions/other thoughts**
• Offers one system linked to all services, leverages whole system. • Demonstrates patient focused care, and enables Albertans to receive seamless, coordinated care, across the continuum of care. • Evidence-based and there are existing successful models in New Zealand and Alaska. • Embraces moving care to community; co-located services and team to work with client.	• Albertans receive care outside their geographic neighbourhood. • Technology advancements required to support communication channels that link provider to provider. • Need to address feasibility in rural context. • Need to determine who holds the funding, governance, and accountability.	• What work is required to build partnerships? And how do you integrate the concept of seamless care amongst silos of care and other stakeholders; what costs will this investment require? • What medical and cultural shifts need to occur to put patients and families at the centre of care? • Where on earth would we start? Please ask Primary Care Networks, community health centres and United Way and a lot of others what they are already doing.

The medical home is patient centred, and we don't need more money to make it happen.

E-mental Health description: would increase access to mental health services to a broader population in a more efficient manner by providing mental health services and information through the Internet and related technologies.

Summary of feedback Why participants liked the option	Challenges noted	Questions/other thoughts
• Can be integrated across all elements of the system, including primary care, mobile response teams and community paramedics. • Assists with overcoming shame stigma, and diverts from Emergency Room, EMS and Calgary Police Service. • Has been evaluated/tested elsewhere and proven effective. • It's innovative and leverages technology. • It's cost-effective, scalable and can reach many populations across the province, including Albertans residing in rural, remote communities and populations vulnerable to poor health outcomes. • Helps doctors and Home Care in supporting patients in their homes.	• Needs to be connected to direct front-line providers. • Need to ensure 24/7 response for those who need help. • Some areas of Alberta still do not have good Internet access i.e. some rural areas. • Need to consider cost implications, and if it's an 'add on' or replacement of programs. • Need to address privacy and confidentiality concerns. • Lacks face-to-face interaction and human connection.	• How can we ensure we have pathways to allow patients to transition from e-health resources to in-person care when they need it? • Is there an objective criterion or evidence to link e-health to positive mental health outcomes? • What are the long-term adverse effects of people accessing e-mental health and not interacting with live people? • Can e–mental health be integrated with neighbourhood health? • How would you reach out/adapt to specific populations (indigenous/ immigrants)?

There is huge potential for cost savings, and the service will reach many Albertans.

Assertive Community Treatment (ACT) description: would increase ongoing case management and support to a range of patients experiencing severe and persistent mental illness by making a significant investment in ACT teams in Calgary and Central Zones.

Summary of feedback Why participants liked the option	Challenges noted	Questions/other thoughts
• Aligns to medical home. • Increases access to services for specific populations. • Is patient-focused and family supportive. • Already proven to be effective with positive outcomes. • Could be delivered by AHS or an external provider. • Demonstrates cost savings by reduced hospitalizations and Emergency Department visits. • Offers team-based approach to care.	• Uncertainty about cost and sustainability. • There are barriers because of different providers offering similar services without collaborating. • Uncertain if we are we using the right people at the most cost-effective wages; need to look at incorporating lower wage professionals, peers and volunteers.	• How does this spread across the province? If not, are we creating disparity? • Can this model be leveraged to help with other healthcare issues of vulnerable populations i.e. integrating, interfacing with chronic disease management? • What are the important differences between AHS and Alex models (financing, availability, effectiveness)? • Is this a specialty program? Is it a community program? Should it be attached to a medical / health home? • How would resource reallocation created by this model be encouraged/planned for/actualized?

How do we expand services to other culture/Indigenous communities?

Innovative Spaces for Living description: would improve outcomes for Albertans who experience barriers to placement in housing due to complex behavioural needs by providing access to appropriate and stable housing through a range of innovative housing and health supports.

Summary of feedback Why participants liked the option	Challenges noted	Questions/other thoughts
• Addresses safety risks to the patient, other patients, and staff when these patients stay for long periods in acute care. • Strong strategy to provide harm reduction to complex medical/mental health patients that may not cope well in structured facilities. • Provides a patient centred and cost-effective alternative to acute care. • If effectively implemented, it would reduce the length of stay in acute care.	• Environment is not suitable for mixing patients/residents with different levels of care but they have to live in the same community/environment. • Need funding to support needs of population. Funding models at present don't match need. As a result, patients revolve through system; they can't manage in home so go to acute. • It's a challenge to upgrade an existing facility because the costs are prohibitive. • Too much regulation.	• Are all the code requirements for these facilities really necessary for effectiveness and safety? There could be high costs to modify and maintain. • How do you create the funding source and governance models? • How would this integrate with other health delivery options? • Can we create a process and model that can be expanded to meet the needs of this population without needing to 'reinvent the wheel' for each client?

The patients served by this option have unique needs that are best served in a community setting.

Children, Youth and Family description: would reduce the reliance of children, youth and families on acute/tertiary care options, including emergency room use, for crisis services; creates a more robust and comprehensive community-based service delivery system which increases access to support and early intervention services in the community. Provides access to enhanced walk-in services, as well as enhanced urgent care response; provides intervention through development of 'Acute At Home' and Day Hospital programs.

Summary of feedback Why participants liked the option	Challenges noted	Questions/other thoughts
• This strategy is absolutely essential; it demonstrates good reach and is transferable to adult addiction and mental health population. • It's less expensive than acute care and offers more suitable care. • Healthy minds create healthy children, early intervention is key, and linking to schools is very positive. • Focus on 'in-school' helps to 'find kids where they live'; opportunity to receive care closer to home (school, home, community).	• It appears with this option that we are 'building' new AHS sites in community vs. leveraging natural community sites (i.e. libraries, sport centres) and integrating AHS into these sites. • Need to see evidence-based evaluation of this option. • Minimal connection between primary care and may create further silos. • Tension exists between school/AHS providing services; need to be more collaborative.	• To what extent can we use/leverage existing services to meet this need? • How does this tie into medical home and e-mental health? • Which area within the option would have the biggest impact? • What would a holistic view look like (treating child as a whole, not just MH concern), including involvement of allied health professionals?

This option increases access to support and early intervention.

Adverse Childhood Experiences description: would reduce risk and rising healthcare costs by implementing the standardized and systematic collection of Adverse Childhood Experiences (ACEs) as part of routine health assessments, and developing appropriate trauma informed intervention pathways for Albertans with high ACEs scores.

Summary of feedback Why participants liked the option	Challenges noted	Questions/other thoughts
• Strong, evidence-based option, and reflects linkage to outcomes. • Incredibly powerful and far reaching across all ministries. • ACEs questionnaire is a tool that needs to be integrated into Mental Health program. • Simply doing the ACE screen creates self-reflection by person and awareness of GP to be 'watchful.' May reduce stigma. • ACEs are absolutely an important part of history that affect the whole patient, and affect how the care is provided and need for care.	• Downstream resources need to be in place to provide support. If ACEs is not understood, it could lead to provider judgment; education is essential. • We don't currently have the support to go with ACE scores; it needs to be embedded education within universities; we still don't have the "anchors" in place to seriously move the dial. • Need to have access to all health professionals and schools (who need to know).	• Are we going to ensure resources are available for patients when we find patients with significant ACE scores? • How could this be embedded across the system? How do we address capacity to respond? • How do we embed ACE in health practitioner training? • Do systems exist that could provide early intervention like child intervention, family violence system, schools?

There's a very active foundation supporting this work. This reflects great stakeholder integration and great community partnership.

Palliative Care description: would support patients dying in place of choice with available options that are in alignment with their goals of care.

Summary of feedback Why participants liked the option	Challenges noted	Questions/other thoughts
• Strives for equitable (not equal) dignity in death. This is community-based healthcare. We are leading, and we need to keep leading. • It's a huge opportunity to increase capacity and capability to build linkages with Medical Home. • There's opportunity to integrate 'share care' approach between palliative and primary care. • Reflects family and patient centred approach. • Bends the curve: provides good care in community to minimize Home Care admissions.	• There is still a lack of awareness, in general, about Advance Care Planning/Goals of Care and option of engaging Palliative and End-of-Life Care services earlier; need to consider how to 'promote' better/earlier. Need to reduce the "nervousness" of dying at home without accessing acute care to do it/get there. Preparing and making the connection with caregivers better and earlier; awareness and education needed. • How do we adapt to palliative care in rural communities? • We can't count on the family support that used to be more common, and the need to access 24/7 care.	• Should the conversations around death be moved forward earlier in life, and manage expectations about what will happen at the end? • Is there any intent to link Medical Assistance in Dying (MAID) with Palliative Care? • What are the linkages with primary care, PCNs, and medical home? Will there be flexibility to shift care practices as needed? • How can the "generalist" practitioner learn the Palliative Care competency, to provide this care as part of the mainstream approach?

There's potential to build on a strong existing program, and maximize roles of all health professions e.g. paramedics.

Restorative/Re-ablement Care description: would support medically stable clients through rehabilitation and restorative care to regain independence and return home safely.

Summary of feedback Why participants liked the option	Challenges noted	Questions/other thoughts
• Going in right direction, and involves patients/clients in their own care path (self-directed); supports independence and self-care. • Helps keep people in their homes; people with lower needs can stay in their homes, in the community, longer term. • If the Home Care Therapy Assistants or trained volunteers are aware of community-based exercise programs or social programs (i.e. Move 'n Mingle), they would encourage/promote connection of the client to those programs once able, and so the social component and sustainability is built in. • Decrease the number of people needing long-term care, and ties with medical home.	• Will there be challenges with continuity and adaptability of services in context of other program provider needs (i.e. shared care coordination)? • We need to explore the ability and willingness of families and support systems to support individuals being successful in this type of program. • We need to continue to educate the public that as an individual, you are ultimately responsible for your own well-being (i.e. lifestyle can help reduce cancers; emergency is not the place for help for a cold).	• What is the difference between community rehabilitation and restorative care? Where does one begin and the other end? Are they both considered rehabilitation)? • Can we promote restorative care at home with public education to help promote the self-accountability piece? Public awareness is expensive but may help over time. • E-Restore? Register your exercises on a phone/web/fit bit? Do virtual group exercises (by webcam)? Teach family "sit to stand" exercises and normalize this (e.g. to be before each meal). • Who will benefit from restorative care? What population is the best for restorative?

This model is already in place. We would save dollars with short term resource allocation for long term care savings and acute care savings.

System Wide Case Management description: would achieve a person-centred approach to the provision of quality health and supportive services in home care and continuing care settings, by providing collaborative quality care in the right place, with increased access to community networks and responsive healthcare services.

Summary of feedback Why participants liked the option	Challenges noted	Questions/other thoughts
• This option helps us stay within our system resources. • Reflects cross-pollination of care strategies through coordination and navigation. • Allows for consistency/ relationship building with one person.	• Has Home Care validated that the system-wide case management approach has been successful i.e. data? • Really great concept but needs to be truly system-wide beyond Home Care. Perhaps this is the post-transformation role of Primary Health Care, and patient needs to be on the team. • Is this too big? How many can be part of a "team" and not be overwhelming to a client? • Need for robust communication/IT to ensure teams/different sectors are connected.	• Can this be spread even broader than the healthcare system? Need linkages with non-profits/community. • Is this a new layer or re-structuring of current services/resources? • Where do you see the resources coming from? Families? Volunteers? • Couldn't Home Care just expand its horizon? • How does the system manager balance duties with other care?

A system wide navigator (case manager) makes great sense.

Indigenous Health description: would improve health of Indigenous persons and communities by integrating traditional health practices and First Nations philosophies and beliefs in culturally appropriate settings within healthcare services.

Summary of feedback Why participants liked the option	Challenges noted	Questions/other thoughts
• Encourages conversations about cultural differences and language issues in the healthcare system, and builds cultural competencies. • Important learning for non-indigenous about prevention/early intervention for indigenous populations • There are existing first-nations reserve based health resources.	• Need to have ability to communicate and achieve continuity for transient population. • Lack of clarity regarding ability to operationalize and around accountability. • Is there an opportunity to integrate education and support into some existing systems around these populations needs? i.e. primary care/continuing care/home care/acute care.	• Can we have cultural liaisons for all larger populations i.e. multicultural health brokers? • How can we increase the number of indigenous providers and support staff in our settings. • How would services to indigenous citizens be integrated with all care?

This option promotes shared accountability to promote indigenous health.

Integrated Community Care description: would promote healthy aging in the community and keep Albertans at home for as long as possible through providing various integrated supports from within the community, the care system, and other community programs such as Home Care, Meals on Wheels, Lifeline, Alzheimer Society, Canadian National Institute for the Blind.

Summary of feedback Why participants liked the option	Challenges noted	Questions/other thoughts
• Aligns with health home. Even if all we did was integrate, we would do better (we waste a lot of money). This is where we need to focus. • Provides opportunity for integration of services; to reduce acute services; to maximize in home/community. • Decreases pressure on Acute Care and Continuing Care beds; decrease admissions and re-admissions to facility care; increase ability for folks to 'age in place'.	• Integrated home care needs budget to match responsibilities. Need to show outcomes so funds from acute savings potentially could be moved to home care • Need to clearly define role of family and a paid support. Home Care 'rules' around authorized services. Medical support/assessment/wound/Activities for Daily Living. • Challenge will be having an integrated care plan; "competition" between agencies; duplication of services; coordination of services (case management model).	• If health system is supposed to support/serve people from cradle to grave, then does provincial/private funding need to be restructured to support that (e.g. funding envelopes)? • Who is going to oversee navigating this (i.e. does it need to be Home Care?) • How do we support the consequences of every patient/family need, skillsets and abilities? • How do we ensure continuity of care provider? How can we improve the present system in Home Care Administration? What happens when Case Managers, Healthcare Aides turn over rapidly and clients experience "new caregivers"?

We need to recognize and share the success stories of those who have lived longer at home.

Alberta Healthy Communities Approach (AHCA) description: would sustain community health and well-being through community engagement, inter-sector collaboration, asset-based community development, political commitment, and healthy public policy.

Summary of feedback Why participants liked the option	Challenges noted	Questions/other thoughts
• Reflects a standardized approach to use data and information to make decisions and identify needs in the community vs. politics. • Promotes innovative approaches and engagement to local governments, a cross sectional approach. • Seems simple to scale up. • Focuses on wellness and prevention; caters to what citizens have been asking for; important for addressing issues and developing impactful strategies for healthy childhood development.	• May be a challenge between collecting data and being able to provide services with outcomes. • How could we make this work in a practical way to ensure uptake, ability for capacity building, and spread? • Is AHS the right one to lead if "we" are a "disease centric" organization (i.e. fixing people when they are sick rather than preventing illness all together); will that perspective be reflected in planning?	• How do you approach this for a large city like Calgary? • Who owns the AHCA? Is it health-led? Municipal? People in the community? Who sustains it? • How do you define community? • How does this inform health services delivery?

This option provides an opportunity to get community more involved in health of community.

Community EMS/Paramedics Program description: would reduce patient flow to AHS acute care; provide immediate or scheduled primary, urgent and specialized healthcare to patients/populations vulnerable to poor health outcomes.

Summary of feedback Why participants liked the option	Challenges noted	Questions/other thoughts
• Builds on a strong foundation that exists, with evidence that supports it. • Reduces hospitalization rates/Emergency Room visits; allows patients to stay in community. • Rapid access; patients seen within 12 – 24 hours of discharge. • Cost effective. • Reflects versatility of EMS scope of practice.	• Need better awareness of what they can do for patient outcome. • We need a sustainability plan, and need to understand how to manage training and other costs long term. • Need to make sure they are connected to primary care, home care, etc. • E-Report documentation is needed to look at history; connect with "nurse in charge," "family physician," etc. work as part of a team. • Need to provide education to community paramedic program re: dementia/geriatrics.	• Are there issues/risks with paramedics working under this medical model? • How can this program use other health practitioners i.e. Nurse Practitioners? • How does/could this integrate with Home Care? • Is this operating in a silo? Is it integrated? • What is the capacity to do this in rural communities • Is EMS able to access and track patient records?

This is an excellent community based program!

Complex High Needs background: would improve the patient experience and health status of the Complex High Needs Populations while reducing demand on the most costly components of the health care system by creating well-designed, integrated, cross-sector healthcare services delivered in the community.

Summary of feedback

Why participants liked the option	Challenges noted	Questions/other thoughts
• Great integrative concept. • This reflects a system transformation to a cross-sector approach to complex case management. • Other programs/partners are doing this; and we can partner. • This deals with the patients full picture, not just a single event. • While this option is resource intensive, there's a large impact for those that have complex issues or those that use the system often.	• This option requires resources and investment to create needed change. • Are there partnerships and services currently existing that can be leveraged without increasing costs? • How do we engage acute care to also be a partner to contribute to the success at complex care needs that unfold in the community? • Resources don't follow client. • Requires that one case manager in a HUB to navigate across service and supports. • How can we predict who needs the intensive case management?	• What are opportunities for sustainability? • How can resources follow client? • After there is an attachment to a primary care provider, how do we identify that person and ensure they are supported, especially if it's not with a traditional healthcare provider? • Can we create a system where the patient will have case management and they don't have to transfer from one service to another? How can we improve our present case management system? • Who has power/is accountable to make this work? • How do we choose the right model – generalist vs. specialist; one person may be indigenous, with addiction and mental health issues, complex needs at end of life… who would case-manage this person?

This option is based on relationships, and breaking down silos and connecting people.

Next steps

AHS will continue to work on the long range plans and the implementation strategies to support them. Progress reports will continue to be provided. While long range planning is taking place, Alberta Health and AHS continue to focus on immediate healthcare priorities.

Acute Care needs were discussed throughout the threads of conversation at the planning session. Those needs are being reviewed and assessed to help determine which services should best take place in the hospitals of the future, and which will be better supported in other community settings and closer to home. Physicians will continue to be part of the decision making process.

Opportunities for further input

Targeted engagement sessions are planned with healthcare providers, and health and community partners to further the work that has been done to date. Engagement with Albertans will occur all along the way, and continue after the long range plan has been approved.

All Albertans are encouraged to comment on the blog about their thoughts on the future of healthcare.

Emerging ideas/questions

Attendees were encouraged to share any ideas that were not represented in the session. Here's a sampling of some of those:

- Consider building 'dementia village' to address dementia issues.
- What if patient information was available across services/across the ministries (not just healthcare), and the patient also had access to it?
- Are we perpetuating the traditional focus on diseases and dollars out into the "community" outside of acute care?
- We need to answer the question – how will we know if we are successful at moving to community health / focus.
- There will never be sufficient expertise at the local level to meet all the needs. An important response to this is capacity building downward and across the system including others responsible for care and human development in the community.

Long Range Planning (LRP) Process

Transitioning care into the community

Calgary and Central Zones

Engagement with Albertans will occur all along the way, and continue after the long range plan has been approved. The **LRP blog** is a forum for Albertans to share their ideas throughout the process.

Sept - 2016	Oct - Dec 2016	Jan - Feb 2017	March 2017	April 2017	May - Aug 2017	Sept 2017	Beyond...
Begin long range planning for future healthcare in our communities.	Community engagement sessions Analysis of data from sessions Development of vision and key focus areas	Develop and analyze health system options and approaches	Review health system options and shortlist	Test and build-out best options for long range plans	Build implementation strategies for Calgary & Central Zones	Draft plans submitted to Alberta Health	Evaluate impacts broadly and in communities Make adjustments Begin implementation

Acute Care needs are being reviewed and assessed to help determine which services should best take place in the hospitals of the future and which will be better supported in other community settings and closer to home.

Helpful information

- Alberta Prevents Cancer website
- Trailer for Paper Tigers movie
- What We Heard Summary from fall sessions

Contact us: *for more information: community.engagement@ahs.ca or call 1-877-275-8830.*
Visit the blog and share more comments or write a guest post!