Integrated Health and Social Care for Vulnerable Seniors in Camrose, Alberta

Siu Mee Cheng¹, PhD Candidate, Cristina Catallo², PhD, RN, Bryan Evans³, PhD, Patrizia Albanese⁴, PhD
¹ Ryerson University

Description

A case study was undertaken of an integrated health and social care initiative, informally termed GAPC established in 2008 that has been able to successfully serve its geriatric clients through collaborative partnership. The Geriatric Assessment Program (GAP) is a program of the Camrose Primary Care Network (PCN). It is designed to meet the needs of an aging population in Camrose and its surrounding areas in Alberta. GAP has partnered with community-based health and social care partners: AHS-Seniors Mental Health Outreach Team, AHS-Homecare, Homemaking and Meals on Wheels (CDSS), financial support services (Service Options for Seniors), hospitals and the Alzheimer’s Society, to name a few. This collective of organizations, GAP, engage in services integration for vulnerable geriatric patients and their caregivers to ensure that they are better supported in the community through enhanced coordinated services delivery. GAPC offers patient assessments, referrals/recommendations among service partners, patient and caregiver education, and health and social services navigation and provision.

Success Enablers

The diagram shows three rings comprised of influencing factors that have made services collaboration and partnership possible. The inner ring of enablers are critical factors (shared culture, vision and goals, communication, dedicated resources and team-based approaches) that play a vital supporting role for the second ring of enabling factors (role clarity, champions, client-centred approach, info-sharing, pre-existing relationships and leadership). The outer ring comprises contextual factors that have an influencing role, negative and/or positive or both in services integration.

Perceived Patient Outcomes

Several perceived patient benefits were identified by GAPC partnering organizations as a result of their integration efforts. It was perceived that clients experience better services coordination, enhanced services navigation, and more appropriate medications as a result of integrated health and social services delivery. The latter is as a result of less reliance on medication utilization because there are more non-medical supports for patients. As a result, clients are receiving more comprehensive care from health and social services providers, they are able to benefit from greater access to care, and more unmet healthcare and social care needs are identified. Healthcare partners report less inappropriate acute care utilization, specifically emergency department visits and hospitalizations. The providers report that these have all resulted in greater quality of life for their patients/clients, the clients are less socially isolated, they are able to stay at home longer, and family members and caregivers are reporting being more supported. Lastly, the providers are seeing less crisis reported among their patients/clients.

Conclusions & Lessons Learned

CONTEXT MATTERS

The GAPC is situated in Camrose, which is a town located in a rural/urban region in northern Alberta. Camrose is well-resourced compared to other towns in the region, and there is a close sense of community among the citizens and health and social care providers. This has created an environment that is supportive of services delivery collaboration.

CHAMPIONS

Individuals in the GACPC who act as champions were critical in ensuring GAPC’s success and sustainability. This included the Primary Care Network and the Alberta Health Services -Seniors Mental Health Outreach. They actively engaged in partnerships with their community partners, and played a role in facilitating engagements among partners.

TURFISM

Issues of territorialism are barriers that service providers had to overcome initially in order to move towards successful services integration. This can negatively impact seamless delivery and patient-centered care because of the lack of role clarity, duplication in services and poor patient experience (i.e., Patient having to tell their story more than once).

COMPLEXITY REQUIRES GREATER COORDINATION

Highly complex patients that suffer from complex healthcare (co-morbidities, frail, dementia) and social care conditions (isolation, income insecurity) require greater advocacy and services coordination among collaborating service providers.

This research was supported by the Social Sciences and Humanities Research Council of Canada. Inquiries about this research may be made to S. Cheng scheng@ryerson.ca