Community Care Innovation Forum

Summary report | March 2023

Highlights from the Community Care Innovation Forum

A pivotal event for the future of home and community care in Alberta gathered a diverse group of more than 70 stakeholders and community members to explore ideas about improving home and community care services for Albertans.

On January 18, 2023, the Continuing Care division of Alberta Health hosted its inaugural Community Care Innovation Forum in Edmonton, Alberta. The forum's objective was to generate ideas that will provide a call for action around home and community care, including how to strengthen integration. Learning from the expertise and lived experiences of all participants, we came away with opportunities to innovate that will spark change for Albertans.

Hosted by Steven Lewis—health policy analyst, researcher, and provocateur—the forum was a platform for candid discussion and creative problem-solving centred on generating ideas that will provide a call for action for home and community care integration and innovation. Attendees engaged with keynote and panel subject matter specialists at provincial, national, and global levels; participated in world café breakout sessions with diverse, multi-stakeholder representatives; and made the most of in-person networking opportunities. They came together and discussed critical themes:

- Caring for people in the community
- Social determinants of health
- Technology-enabled health and care

Conversations around supporting clients, caregivers, Indigenous populations, and rural communities cut across all thematic areas.

This post-forum report dives into the six key takeaways from the discussions, keynotes and panel highlights, world café recaps, and the next steps to continue driving opportunities to improve home and community care in the province.

Contents

1.

Six key takeaways from the Community Care Innovation Forum

1 Home and community care needs major change—it has for decades. Our challenge is to seize this golden opportunity and accelerate system change together.

Everyone who took part in the Community Care Innovation Forum saw the same opportunity: improve home and community care services for Albertans by bringing stakeholders together to accelerate system change. We all recognize the need to shift care to the community, but there is so much to be done and little certainty about how to start. What we know is that in the past, top-down approaches to change have not succeeded. What's the alternative?

Nothing short of a social movement will initiate our journey into a future where Albertans can receive the right care, in the right place, at the right time. It will take people and advocacy to bring about transformations that improve the coordination of health and social sectors and strengthen support for families and caregivers. The movement is the change platform—and by bringing more than 70 stakeholders and community members together for the inaugural Community Care Innovation Forum, we created a **safe space to build trust, communicate openly and candidly, and work through difficult conversations to advance real change.**

"There is a crisis in our health care system, but challenges present tremendous opportunities. Never waste a crisis."

"There is a force to be tapped with the elderly. And guess what, we've got the time."

"As we embark on our transformation journey, what's really important is that we start to move forward with actions. We're not going to get it right 100% of the time, but we're in this together, so let's get started."

2 We must improve our ability to provide health care to Albertans in their homes and communities.

Prior to the Community Care Innovation Forum, Alberta Health hosted the Modernizing Alberta's Primary Health Care System (MAPS) Innovation Forum on January 16-17. The MAPS Innovation Forum had valuable goals:

- expand stakeholders' thinking around innovative ideas
- leverage data-informed evidence to co-create solutions
- discuss potential actions for modernizing Alberta's primary health care system

With a focus on innovative ideas, data-driven solutions and collaborative actions, the MAPS Innovation Forum sparked exciting discussions and revealed new possibilities for transforming primary health care in Alberta. A key highlight from both the MAPS and the Community Care Innovation Forums was the consensus that improving home and community care has the potential to greatly enhance primary health care:

- making access to quality care more equitable for all, especially in rural and remote regions
- optimizing team-based care
- enabling coordination and integration between health and social services
- better meeting the needs of vulnerable and underserved populations
- addressing the unique needs of Indigenous peoples and communities

But to achieve a citizen-centred health care system in Alberta, primary health care and home and community care need to evolve together in lockstep. **Alberta has a very real opportunity at this time to build better bridges.**

"Today's Community Care Innovation Forum really upped the ante from yesterday's primary health care innovation forum. Having the two forums back-to-back was an inspiring thing to do as it sets a bold vision for an integrated, innovative health care system in our province."

"We're talking to each other more than I've ever seen in my 30-year health care career. We've realized that none of us can do this independently, so let's work as a team to transform the system."

"In Denmark, we think of primary health care and community care as one. We call them care trusts and refer to our "patients" as citizens. These are small but powerful changes that help bring people along on a transformation journey."

3 Strong leadership and inclusive, compelling stories drive change. We must compel leaders to craft the story and measure the outcomes.

Themes of strong leadership, unified vision and accountability emerged throughout the Community Care Innovation Forum. Successful transformation journeys start and grow with a story so persuasive that it inspires a multitude of people to break from the comfortable familiarity of the status quo and create something better.

Participants at the Forum mutually understood that leadership sets the tone for cultural shifts—which will be necessary for a thriving home and community care system across Alberta. **When robust accountabilities accompany strong leadership, it is possible to set a strategic direction that aligns with community needs.** This is the key to truly meeting those needs. As Health Minister Copping noted in his introduction, measurable outcomes allow us to track progress, evaluate the success of our change efforts and enable us to correct our course when things don't go as planned. That makes them crucial to our transformation journey.

"As Dr. Sinha highlighted, 100% of Canadians 65 years of age and older report that they plan on supporting themselves to live safely and independently in their own homes for as long as possible. There's a universal desire to age in place, so why isn't it our collective goal to support people to stay in their homes? We celebrate when our community gets a 500-room nursing home because we have no other options. I think it's time to invest in some 'R&D' (rob and duplicate) and follow Denmark's lead by shifting the mindset and narrative to what Albertans actually want."

4 If we don't design for community needs, we won't meet them. It's time to implement a citizen-centric approach to delivering home and community care.

Almost every keynote, panel discussion and world café touched on enabling citizen-centred approaches to home and community care transformation in Alberta. By focusing on the needs, preferences and goals of individuals and their communities, we're putting citizens at the front and centre. When we value and embrace the people who access home and community care services as true partners, we can co-design programs and services that more effectively address the unique needs and circumstances of patients, clients and family caregivers, leading to improved outcomes, experiences and higher levels of satisfaction.

Both Charlotte Kira Kimby and Dr. Samir Sinha spoke about the importance of taking a proactive, citizen-centric approach to enable people to age in the *right* place. Danish municipalities work with and organize rehabilitation in different ways, but they always prioritize two focus areas:

- the individual citizen
- interdisciplinary collaboration

Further, **municipal health programs place significant importance on preventive initiatives to help people maintain their health and quality of life.** For example, once you turn 75, a preventive team will visit your home to discuss your current life situation and overall well-being.

"One size doesn't fit all when it comes to home and community care. But as diverse as our Canadian population is, the common denominator is that citizens want to age in their own communities, so it's our job to support them to do so."

"In Denmark, we refer to them as citizens, not patients. This simple, yet powerful word choice makes a big difference in how our overall system operates."

"I always appreciate how the Danes don't find this word choice a big deal, but it always surprises us North Americans when they hear this."

5 How do we enable a more innovative, integrated, citizen-centric system with measurable outcomes? Make our data work harder.

The Forum explored the role that technology can play in the community to help optimize independence and quality of life for people and their support networks. Data was a critical topic for consideration under the technology umbrella. Participants discussed using data and analytics to strengthen integration and ultimately improve home and community care services for Albertans.

Attendees agreed that if we're looking for ways to accelerate our transformation, we need to unlock the power of connected data. The system-wide benefits of getting this right are overwhelmingly compelling:

- improve the overall patient-citizen experience
- increase patient-citizen engagement
- use resources more efficiently and effectively
- streamline operations and coordination of services between health and social care providers
- enhance decision-making for patients and their family caregivers

The issue of data interoperability came up in both Innovation Forums, and the consensus was that the issue comes back to accountability. We must ensure the glut of information stored in disparate locations becomes more accessible. **Siloed systems need to start talking to one another.**

"Over the last three days, it has become very clear that there isn't one understanding of Alberta's health care system and the services available. If I could suggest a short-term, quick win it would be to use technology to overcome the siloes, fragmentation and general lack of awareness around how to navigate the system."

"Spotify can ping me when my favourite artists are coming to town, and Amazon tells me what books I'll like. The transformational power of the internet, data and analytics is massive in continuing care. However, if we're trying to build a truly patient-centric health care system, where I can, for example, select in real time that I'd like my home care visit to come on Thursday vs. Friday, let's look beyond the health care industry to get this right."

"We have the power in our data systems to fix the siloes, and I can't think of a better incentive than putting an informed patient-citizen at the centre of their care. Let's stop letting perfect be the enemy of good."

6 We need to be agile. We need to be all in. Let's make a bold, deliberate and sustained commitment to transform home and community care.

Throughout the Forum, we heard loud and clear that transforming home and community care in Alberta requires full commitment from stakeholders and community members. It also requires a willingness to invest (or reallocate) both money and resources. Half-measures or actions that don't withstand the four-year political cycle will fail.

Identifying and honestly and respectfully discussing obstacles to change is also important. We all own successes and failures, and progress is a team sport. Once the barriers to progress have been identified, we can focus on removing them creatively.

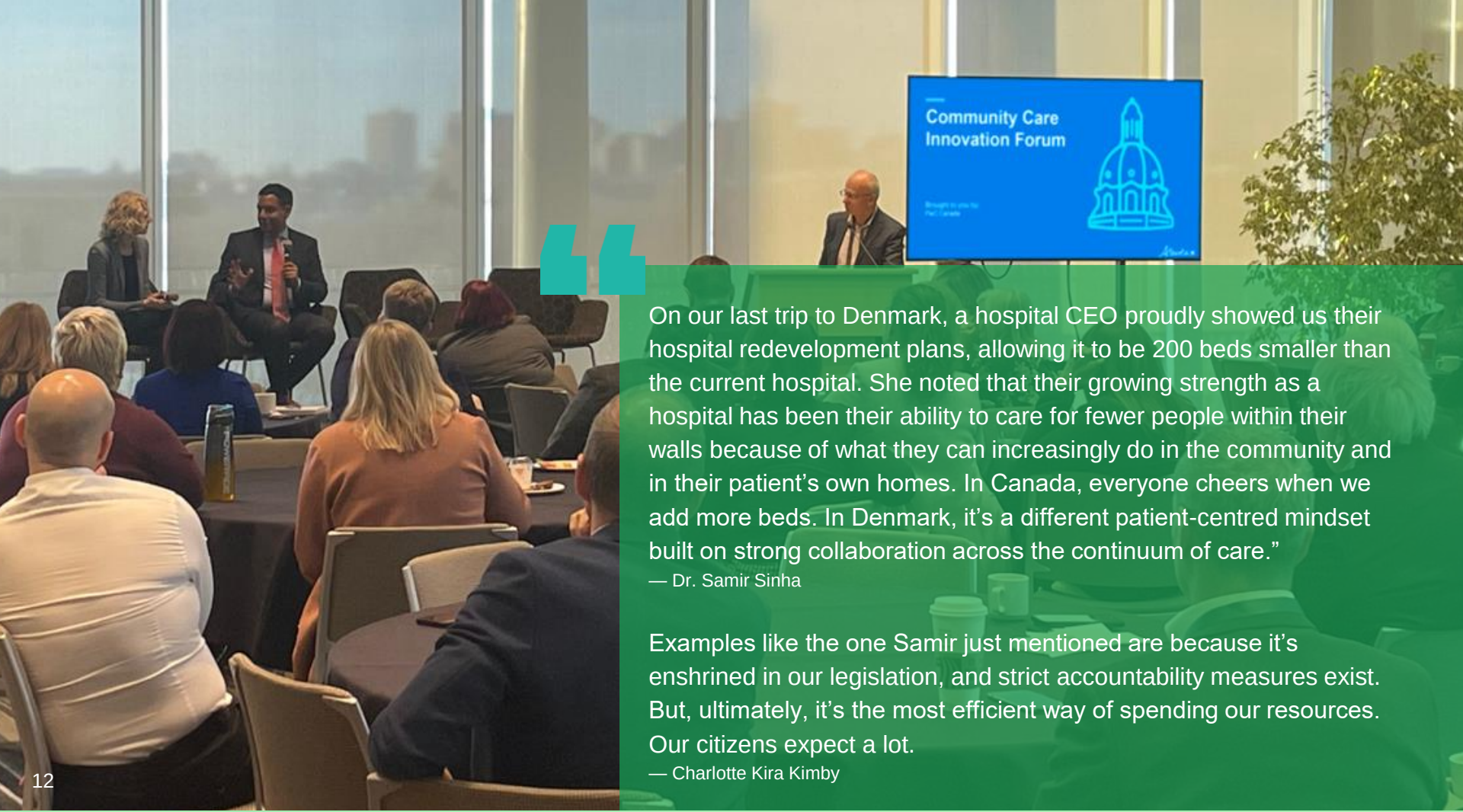
As Charlotte Kira Kimby noted, we should give ourselves the space and grace to fail. We're not going to get this right 100% of the time. So, let's make this transformation story one of progress rather than perfection. Let's not fear taking significant steps to create long-term value—the outcomes will take decades to play out. **We need to start, build momentum, invite innovation and go forward boldly.**

“Continuing care has been getting a lot of assignments—much recommended, little implemented. Let’s use today as a catalyst to change this.”

“Let’s be like Denmark and do something bold like hold the line on nursing home construction.”

2.

Keynotes and panels



On our last trip to Denmark, a hospital CEO proudly showed us their hospital redevelopment plans, allowing it to be 200 beds smaller than the current hospital. She noted that their growing strength as a hospital has been their ability to care for fewer people within their walls because of what they can increasingly do in the community and in their patient's own homes. In Canada, everyone cheers when we add more beds. In Denmark, it's a different patient-centred mindset built on strong collaboration across the continuum of care."

— Dr. Samir Sinha

Examples like the one Samir just mentioned are because it's enshrined in our legislation, and strict accountability measures exist. But, ultimately, it's the most efficient way of spending our resources. Our citizens expect a lot.

— Charlotte Kira Kimby

Charlotte Kira Kimby

The Danish model

The vast majority of citizens wish to stay as long as possible in their own homes in familiar surroundings. To accommodate their wishes, physical training and assisted living technology are particularly important.

Roles and responsibilities

The municipalities in Denmark are organized with direct local elections, however, they have no lawmaking powers. They're under obligation to implement the National Act on Social Services, which can be described as a 'framework legislation'. In other words, it sets out in detail **what to do**, not **how to do it**. The "how" is up to the municipalities, and there's great variation among the municipalities based on the needs in the community. Furthermore, municipalities can decide on methods, they can choose private enterprises or cooperation with non-profit organizations.

Key services offered by Danish municipalities

The 98 Danish municipalities are responsible for a number of health and social services. Local health and elderly care services include **disease prevention and health promotion**, **rehabilitation** outside of the hospital, **nursing home and home nursing**, and **home care services**.

What works?

Experiences from Danish municipalities

- A perspective on caring: Not home care service vs. no home care service, but the necessary home care service.
- Danish municipalities work with and organize rehabilitation in different ways, but the central focus must be on the individual citizen and interdisciplinary collaboration.
- The citizen's motivation is the driving force and therefore, essential.
- Moving towards a rehabilitative culture: It's a way of thinking, not just a way of doing.

"Preventive care is key in Denmark. And we start early by promoting healthy habits from an early age. For example, all school children are provided with a healthy breakfast, and schools prioritize physical activity with mandatory recess and integrating physical activity into the school day."

"Denmark is not exempt from the global health care staff shortages and burnout. So what's different? They're serious about investing and adopting new technology to address these issues, without compromising care."

Dr. Samir Sinha

The pandemic, and our experiences, have influenced our views on where Canadians want to age

- Canadian older adults were particularly impacted by the COVID-19 pandemic, with over 80% of the COVID-19 related deaths during the first wave occurring in long-term care homes.
- Today access to continuing care typically means you need to leave your home, or leave your community and that's a shame.
- 91% of Canadians of all ages, and almost 100% of Canadians 65 years of age and older report that they plan on supporting themselves to live safely and independently in their own homes for as long as possible.
- However, avoiding caregiver burnout, whether it's formal or informal, must be addressed. Between 2019 and 2050, there will be approximately 30% fewer close family members available to provide unpaid care.

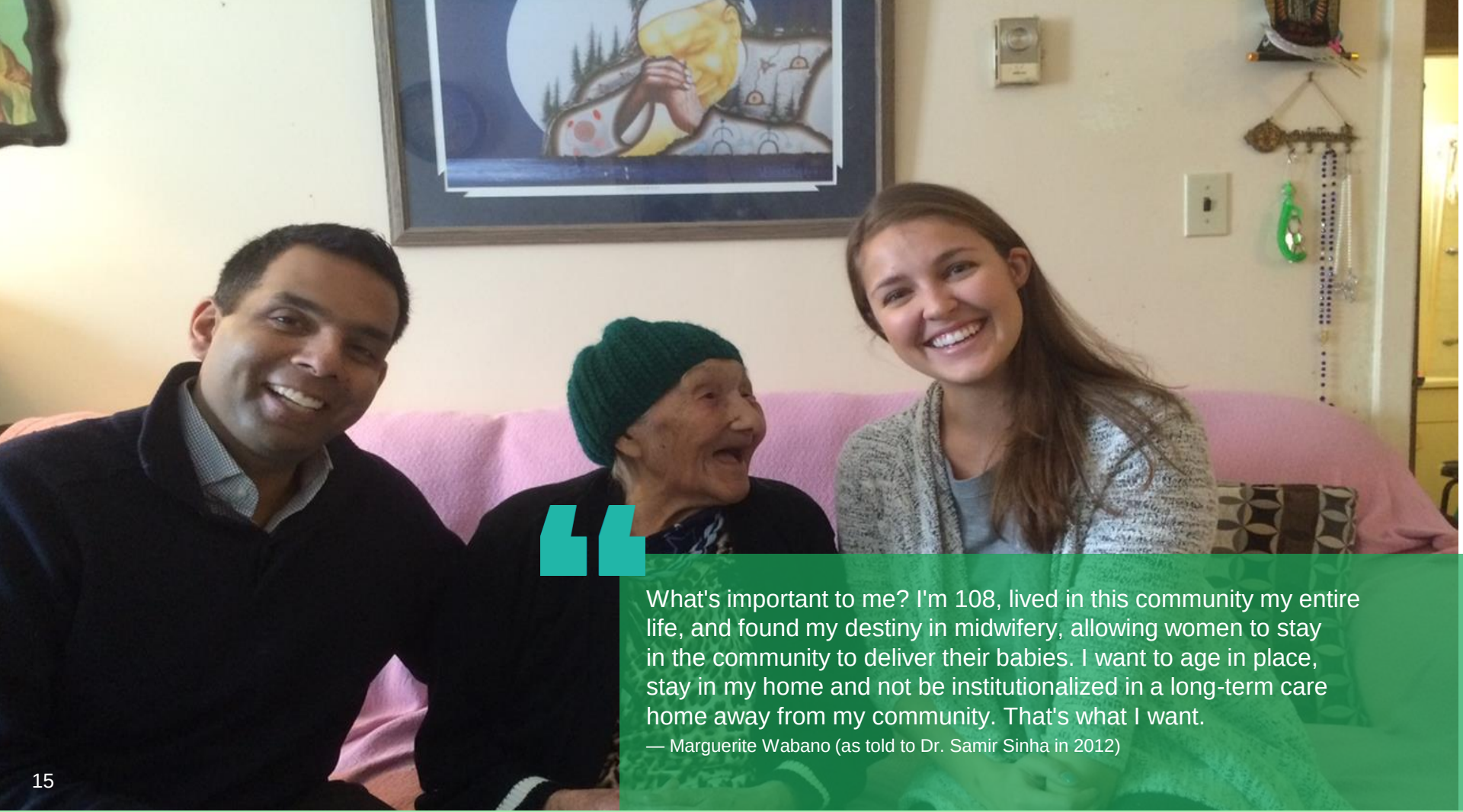
Appreciation for how ageing-in-the-right-place needs to begin with the development of age-friendly communities and more innovative and flexible models of community-based care

- Not only do Canadians overwhelmingly prefer to age and receive care in their homes and communities for as long as possible — it's often far less expensive than care in continuing care homes. So what's stopping us from re-allocating funds?
- Small and remote communities often do not support service and health care economies of scale. But as long as we look at rural problems with urban solutions we will miss the opportunities that exist.

Enabling a home and community care transformation

- Enabling aging in the right place requires a shift in traditional thinking.
- From enabling age friendly communities to virtual LTC at home models, there are all different models of care that can create alternative housing options that can better promote independence, dignity and respect.
- Innovative continuing care strategies can only succeed through collaborations and partnerships and can ensure the sustainability of our health and continuing care systems for years to come.

"The Danes have it right and have informed a lot of my thinking in order to support people to age in place."



> What's important to me? I'm 108, lived in this community my entire life, and found my destiny in midwifery, allowing women to stay in the community to deliver their babies. I want to age in place, stay in my home and not be institutionalized in a long-term care home away from my community. That's what I want.
>
> — Marguerite Wabano (as told to Dr. Samir Sinha in 2012)

Community care integration panel perspectives

What is the single biggest gap in community care in Alberta? What will it take to fill that gap?

- System navigation is a significant challenge; there are a lot of incredible services available to Albertans that there's a general lack of awareness around.
- The complexity of the system impacts internal mechanisms as well. There is a lack of role clarity and a need for greater coordination amongst care providers.

Is primary health care ready to take on some responsibility here?

- The question is about the composition of primary care teams and if they are made up of the correct individuals.
- Medical homes are the introduction to the community care system and they must improve their communication with the broader sector.
- We desperately need some role clarity when it comes to finding the "Holy Grail answer to team-based care."

Canada still has an institutional continuing care culture. Clients and families tend to want more options in and support for community-based care. Does Alberta need to take a bold step, whether setting specific targets to reduce the rate of institutionalization, follow Denmark's lead by enshrining policy in legislation, or something similar?

- No one owns the problem. There must be proper governance and accountability to solve it.
- Reflection is required on resource allocation and how it can be done differently moving forward to better support community-based care.
- We cheer when new hospitals are built or a seniors home comes to our community. This is because today, we have no alternative.
- It sometimes feels like we're on a runaway train, barreling down the tracks in a direction no one actually wants to go. Let's be bold and change directions before it's too late.

3.

World Cafés

World Café themes

All participants circulated among the the three World Café themes listed below:

01

Caring for people in the community

How can we enable integrated community care models that meet the health and home care needs of people and communities?

Facilitators:
Dr. Jennifer Njenga
Dr. Richard Lewanczuk

02

Social determinants of health

How do we improve navigation and integration of community based services to support people to remain in their homes and communities as they age?

Facilitators:
Karen McDonald
Lisa Stebbins

03

Technology-enabled health and care

What role can technology play in the community to help optimize independence and quality of life for people and their support networks?

Facilitators:
Reg Joseph
Tim Murphy

Cross-cutting theme

Supporting clients, caregivers, Indigenous populations, and rural communities

How are systems designed with and for people?

What is the client and caregiver experience?

How will this impact rural and remote communities?

How will this benefit Indigenous peoples?

1.

Caring for people in the community

Why don’t we look at solving the problem of access and appropriate care in rural and remote communities, then bring the solutions to urban centres? Of course, we know the reverse doesn’t work, but perhaps we start by focusing on trying to solve outside the city limits.

CARING for PEOPLE in the COMMUNITY

COORDINATION • COLLABORATION • PARTNERSHIP

Caring for people in the community

1

What are your recommendations to achieve the best possible community care for Albertans?

Prioritize support for family caregivers

- Increase voice and participation of family caregivers
- Build trust, set expectations, shared understanding

Address waitlists

- Decentralization of case management to community
- More programs, more access points

Recognize that continuing care is HOME

- Shift government perspective on facility-based care to accountabilities for home-based care

Improve access, funding, investment and infrastructure for adult day programs

- The programs present an opportunity to reduce caregiver burden and burnout

Invest in the workforce

- Staffing shortages are reaching a crisis point
- Need to focus on equity, recruitment, retention

Clarify roles and responsibilities

- Government, health care providers and the broader community don’t know what options are available
- Educate providers and people (family and caregivers too) about culturally safe care and services

Caring for people in the community

2

What actionable steps would you suggest are taken first to support the recommendations and accelerate change?

Potential actions	Barriers
• Invest in adult day programs with multiple access points and keep these outside of the formal health system. Provide infrastructure and social programing that is targeted for specific populations and groups and meets people where they are at directly in the community (e.g. seniors, adults with special needs, culture, interests, gender, etc.).	• Financial investments • Focus on community programs and services
• Increase respite beds and in-home services with particularly focus on rural Alberta	• Capacity • Financial investments
• Improve overall navigation and coordination - between providers, settings, services, information barriers, needs-based, invest in more tools and training.	• Integrated education and training • Data and technology
• Address funding inequities for First Nations communities and Indigenous people - focusing on both adults and children/youth.	• Equity • Financial investments
• Establish a targeted community workforce strategy that addresses wage equity and optimization, career pathways and accelerated licensing, and more nurse practitioners, and social workers and rehabilitation providers.	• Workforce strategy • Intersectoral coordination and collaboration across government departments and academia
• Organize and fund health and social services around the person and populations - follow the lead of Denmark or New Zealand. Reset funding models by social mapping and health needs assessments of communities. Address the unique needs of rural communities (transportation, mobile services, outreach).	• Lack of integrated data and standards • Limited community health governance and intergovernmental collaboration

2.

Social determinants of health

We see the social determinants of health as foundational to address on an individual level. But unfortunately, most providers don’t want to ask about the social determinants of health because they don’t have the awareness, tools and resources to refer into.


SOCIAL DETERMINANTS of HEALTH
ACCESSIBILITY • EQUITY • INTEGRATION • COLLABORATION
LACK OF CLARITY
IDENTIFY PEOPLE IN NEED
COMPLETE NEEDS OF THE INDIVIDUAL
BURNOUT
HOW TO MEASURE SUCCESS?
ISSUES
"We need to build a system that catches those that typically fall through the cracks."
STRENGTHEN CONNECTIONS
DEVELOP RELATIONSHIPS
BREAK BARRIERS
REWARD WELLNESS
PEOPLE CENTRED
ONE SIZE DOES NOT FIT ALL
CULTURE CHANGE
ACTIONS

Social determinants of health

1

Where is the social support system weakest, and how does it affect the need for, or effectiveness of, the continuing care system?

Lack of governance and accountability

- Currently no shared vision for home and community care in Alberta, therefore we can't expect allowing people to age in their homes, or in the *right* place, to be a collective goal we're all working towards.
- Currently no measurable outcomes or goals that we can be held accountable for, because there isn't one governing body responsible for home and community care.

Communication

- One of our weakest links in primary and continuing care, that could be improved if we invest in technology, data systems, analytics and most importantly, a citizen-centered approach to care.

The ability to identify those in need proactively and use a prevention mindset

- We're currently relying on emergent situations, but need to embrace a far more proactive approach like Denmark (ex. new parents receive a minimum of five visits, when you turn 75 you're offered care from a team to support your future needs).

Rigid, siloed system, with little support, tools and resources for the citizens, providers and caregivers

- Social determinants of health need to be addressed on an individual level. However, providers don't want to ask about the social determinants of health because they don't have the tools, resources or awareness of the system to refer into.
- If our providers can't navigate the current system, we can't expect citizens to either. We currently make navigating the system the problem of the patients and caregivers, which needs to change.

Transformation → technology/data/analytics

- Technology and data are both weak links in our system, but before we invest in the latest technology, we need to transform (fix) our system.
- Technology (hardware) isn't available for our vulnerable population

Social determinants of health

2

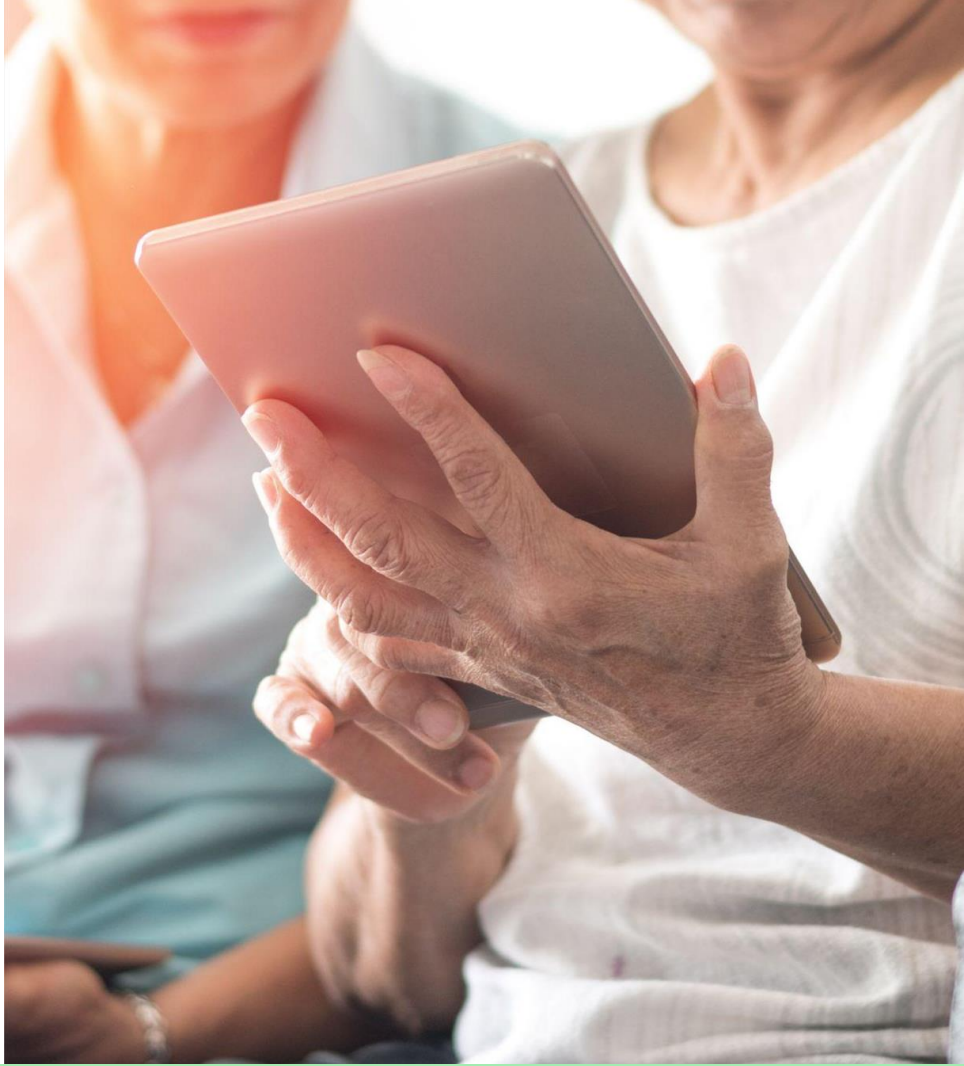
What policies and/or investments would you recommend to address these problems?

Potential actions	Barriers
• Embrace technology in social support • Integrate Connect Care with the social system • Develop and uphold strong accountability measures for leadership	• Lack of flexibility, innovation and accountability in the system
• Build capacity for community members to train others in their own community • Greater investment in care workers and mobile care for rural communities • Utilize resources more thoughtfully	• Barriers of access for rural and vulnerable populations
• Implement a multidisciplinary team approach to care • Identify opportunities for increased communication in the system • Invest in interagency supports	• Limited intersectoral collaboration
• Invest in additional resources • Implement cultural approaches to support programs	• Workforce support
• Invest in system navigation information and mapping • Communication must be available and accessible • Cellphone distribution to vulnerable seniors	• Challenges navigating the system
• Spread and scale impactful programs • Use a citizen-centred approach	• Lack of client voice
• Implement home-based visits by health care teams • Change who controls resource allocation - enable the pooling of resources	• System isn't designed to allow people to age in the *right* place

3.

Technology-enabled health and care

Our technology and data systems have the power to fix the siloes. I can’t think of a better incentive than putting an informed patient-citizen at the centre of their care. So, as the Minister said, ‘let’s spark some action.’

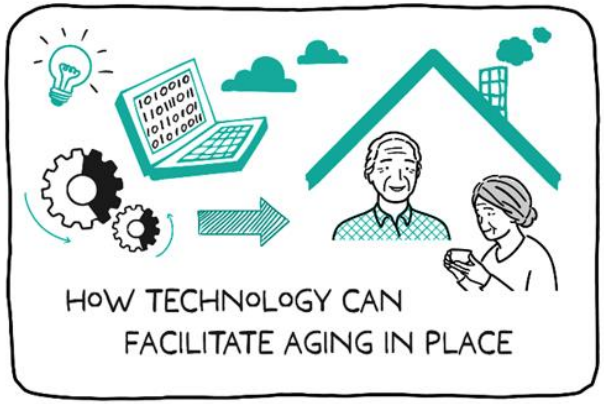


TECHNOLOGY-ENABLED HEALTH and CARE

COORDINATION • COMMUNICATION • COLLABORATION • ACCESSIBILITY • PRODUCTIVITY

No ACCOUNTABILITY

WE NEED TO CHANGE OUR MINDSET AROUND ACCESS TO DATA



"Let's turn up the volume on the fact that tech advancements are allowing more people to be able to receive complex care in their own home."

CREATE AMAZON FOR ALBERTA HOME & COMMUNITY CARE SYSTEM

COMMUNICATION IS THE WEAKEST LINK
SYSTEMS DON'T TALK TO EACH OTHER

DENMARK ALSO HAS A TALENT SHORTAGE, SO LET'S FOLLOW THEIR LEAD AND INVEST IN LEADING EDGE TECHNOLOGY TO OPTIMIZE HEALTH CARE

ENABLE CITIZENS TO MAKE BETTER DECISIONS WITH TRANSPARENCY OF INFO

Technology-enabled health and care

1

What role can technology play in the community to help optimize independence and quality of life for people and their support networks?

The ability to facilitate the coordination and communication of health care teams and patients

- Crowdsourcing services based on patient needs
- Enhanced Nurse Line after-hours
- Automated broker role can take cultural sensitivities into consideration and involve patient families
- Asynchronous care

Assists with collaboration among health care teams

- Automated patient pathways for Provider awareness

Improves accessibility to care

- Various modalities for technology access (e.g. voice-enabled devices)
- Enabling access to unscheduled needs
- Connect patients to care options and enable communities of support

Productivity enhancement and automation

- Tech-enabled self management
- Tech-enabled navigation and care pathways
- Leverage technology to trigger in-person connection

Data and privacy

- Better connectivity for existing pathways between a variety of providers
- Better research and patient participation

Technology-enabled health and care

2

What are the barriers to incorporating these technologies and the potential actions that need to be taken?

Potential Actions	Barriers
• Integration (EMR) • Build a tangible set of integration standards • Enable interoperability / open APIs • Start small and scale interconnectivity solutions (i.e. minimum viable products) • Conduct research to make data-driven decisions around where to begin closing the integration gap	• Fragmentation
• Training and technology support • Challenge assumptions around technology knowledge and be mindful that not everyone will use technology	• Varying levels of technological literacy
• Implement connectivity infrastructure, particularly in rural and Indigenous communities (i.e. 5G fixed wireless access)	• Wifi and broadband access
• Develop funding models and fee codes to support providing tech devices (i.e.smartphones, wearables, smart home technology, etc.) to a broader population	• Access to devices
• Co-create technology with patients and providers to effectively integrate their lived experience	• Inadequate technology design
• Ensure that individuals have the autonomy to use technology where it makes sense for them: technology should empower not hinder	• Provider and caregiver burnout
• Build an online catalogue of services available to Albertans	• Complexity of health and social service systems

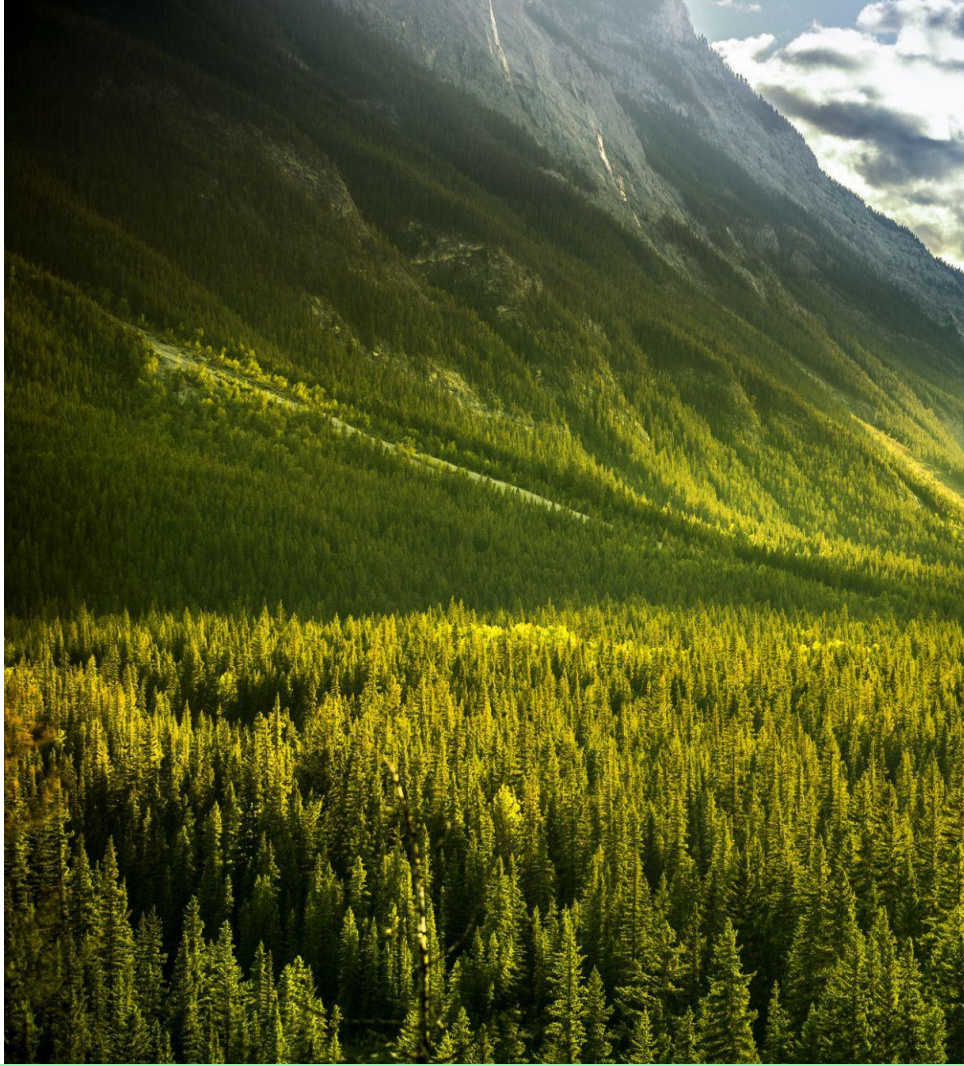
4.

Next steps

Next steps

Looking to the future, the vast array of thought, perspective, and insight gathered throughout the Innovation Forum will be used to accelerate system changes. On top of this, the value that stems from bringing together many different thought leaders, experts, health care providers, policy makers, and community members is significant. The intention is to carry this momentum forward as the change journey continues. There is further opportunity for these voices to be brought together to build trust, innovate, and transform home and community care in the province, and additional consultation platforms can be expected.

"Building more hospital beds and nursing homes is no longer the answer. Instead, it's time to turn to the citizens and ask them what they want and need, then step back and figure out how to make it happen and measure progress. Unleashing that power and promoting collaboration make it more affordable and better aligned with people's wants."



Thank you for allowing
me to be part of your circle
as you come together together
to talk about actions that will
help people who are suffering,
need services, and are crying
out for help. As you go forward,
take this wisdom with you
and continue to dialogue
with one another.

Ella Arcand
Elder, Alexander First Nation

5.

Appendix

It's January 2028, and you're reflecting on your time at the Community Care Innovation Forum in January 2023. What's something that would demonstrate to you that home and community care services have improved for Albertans?

What success looks like

Aging in place

All Albertans with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others.
Communities come together to keep elders safe and at home.
Increased system and community/neighbourhood support to keep people at home if that is their choice.
More Albertans have the option to stay at home when needing care instead of moving to a facility.
More older adult Albertans have access to the services and supports that they need to successfully age in the place that they choose.
People are able to age in place and maintain their quality of life.
That complex care and a restorative approach can be done well at home.

What success looks like

Coordination and integration of care

Alignment and integration with primary care providers.
Caregivers are recognized as part of the connected care system and given appropriate supports.
Coordination of services across the health care system.
Formal connections are in place that connect caregivers and care recipients with the services they need in their community.
There is better coordination between health, social services and the social sector, so that all Albertans can age well in place.

What success looks like

Workforce and funding

Home care funding/delivery models have evolved to create an attractive career opportunity for health care workers.
Home care has become a desirable and sustainable career path for health care workers.
Immediate access regardless of where you live; enhanced capacity in acute care and facility based care; increased attraction and retention of Home Care staff.
Provide funding and support for the entire continuing care services.
The critical role of the community based senior services sector (CBSS) is valued, adequately funded and their capacity is enhanced.

What success looks like

Access to services

A comprehensive, coordinated provincial non-medical support program is accessible, available and marketed to ALL seniors.
Access / resources/ services equal to AHS in First Nation Communities.
Accessible continuing care homes, services, support and facilities on all First Nations in Alberta.
In-home services accessible to all (such as respite, IV therapies, and vac dressings).
More home care help/hours are available and accessible to those in need.
Transportation is accessible and available to get citizens to non-emergency medical appointments, and there are financial supports available for folks who require it.

What success looks like

Quality of care

Early access to quality palliative care.
Family members/care partners are feeling supported in caring for their family member.
Increased patient / family reports satisfaction with home care / LTC access and services.
Reduced 30 day readmission rates for our clients. Reduced DLO patients in hospital. Improved culture towards home care utilization in community.
That complex care and a restorative approach can be done well at home.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Thank you