Specialized Community Services Programs

Why:

- 35 year old male with schizophrenia, tobacco dependence, and diabetes
    - Can expect a 25 year decreased life span with increased medical costs
- 60 year old female with diabetes, CHF and depression
    - Frequent (re)hospitalizations, poor self-management, multiple co-morbidities, access care from several service streams, candidate for early Long-Term Care
- 87 year old male, lives alone with no family residing in the province. Poor nutritional state, difficulty mobilizing and managing basic activities of independent living
    - Declining health is not monitored or supported

Policy Objective:

Primary care networks (PCNs) will be established across British Columbia to provide comprehensive, person-centred, culturally safe, quality primary care services to the population of a Community Health Service Area (CHSA) and, as required, coordinate patients' access to specialized community services programs (SCSPs), and the broader health system.

SCSPs linked to PCNs will focus on Adults with Complex Medical Conditions and/or Frailty; Moderate to Severe Mental Health and Substance Use; Cancer Care; and Surgery, to achieve meaningful health outcomes (effectiveness) and a quality service experience linked to key service attributes (accessibility, appropriateness, acceptability, safety, efficiency).

When patients require more specialized health care services related to mental health and substance use, surgery, cancer care or managing complex medical issues and/or frailty, they should not be left to find their way between multiple services, multiple wait lists and multiple providers resulting in sub-optimal, uncoordinated and inefficient care. The integrated system of care supports a redesign and link these fragmented services into integrated and coordinated programs that meet the needs of the population. Care will be effective and holistic, comprehensive, and coordinated, as it wraps around the needs of the individual patient and their family resulting in a quality service experience.

Once referred to a specialized program, patients will have access to the care services and management they need. Any referrals and appointments will be coordinated for them, along with education and self-management support and access to care or advice. Whether they live in a rural area, small town, or big city –specialized and primary care providers will communicate with patients and each other –providing citizens with an understandable, patient-centred system of care.

When:

Ten communities have self-identified as being early adopters and will realize the standards of care for PCN and SCSP.

Who:

The PCN development is a structured partnership between Divisions of Family Practice, the Health Authorities, First Nations and potentially other community partners via their Collaborative Services Committee (CSC). The SCSP is largely based on standardizing direct clinical care and service delivery by health authorities but will demand effective and efficient linkages and transitions between PCN and the SCSP services.

What:

Key Attributes of the SCSP's include:

Clear and accessible linkages across Primary and Community Care for patients/families and providers, including:

a. SCSP's support one or more PCN's.
b. A known single point of contact supports providers to connect as required.
c. Clients and families have access to a knowledgeable person who can assist with questions about their health and care.
d. A single designated leader has fiscal and operational accountability for all aspects of the SCSP to enable flexibility and responsiveness.
e. Access to necessary hospital and diagnostic services is direct, bypassing emergency departments (where clinically appropriate).

Team-based care practices are enabled, supported and resourced, including:

f. Services are designed into a single population based program and access barriers within service streams are removed.
g. Adequately resourced interdisciplinary teams within each SCSP consist of an appropriate mix of disciplines and possess the competencies to deliver seamless, integrated care to their assigned caseload and are responsible for:
    i. Efficient processes to enable timely access to appropriate services.
    ii. Clinical pathways and protocols to ensure evidence based care and smooth transitions for clients within the SCSP.
    iii. Providing the necessary scheduled care as identified within the care plan and response to unscheduled or urgent care needs to avoid hospital and emergency department admissions.
    iv. Coordinating and organizing services to support timely and early discharge from hospital care back to community settings.

Technology is leveraged to support alternate methods of care delivery and efficient information sharing, including:

h. Appropriate data collection and reporting, e.g. performance monitoring and minimum reporting requirements within health authorities.
i. Supporting alternate methods of care delivery.
j. Enabling communication between team members when co-location isn't possible.

k. Sharing plans of care between providers, e.g. care planning, electronic documentation and remote consultation.