Building Bridges in Alberta's Continuing Care System: Navigation and Integration

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CONTENTS

INTRODUCTION

Alberta's continuing care sector is undergoing transformative change, driven by the government's health system modernization agenda and the need to address longstanding challenges in system navigation. As the province transitions towards a more integrated, patient-centered model, system navigation has emerged as a critical theme. This document provides a comprehensive summary of the current landscape, including the historical, structural, and systemic challenges facing Alberta's continuing care system, as well as insights and actionable recommendations gathered from continuing care operators.

About the Alberta Continuing Care Association (ACCA)

The Alberta Continuing Care Association (ACCA) is a non-profit, voluntary organization that represents diverse providers of continuing care services across Alberta. Our membership includes a unique alliance of independent and non-profit owners and operators of Home and Community Care and Continuing Care Homes (Types A, B, and C), as well as providers of quality products and services that support the sector. ACCA serves as the collective voice for our members and fosters collaboration to enhance the quality of care and services across the province.

ACCA has played a pivotal role in advocating for practical, operator-informed solutions that bridge the gap between policy and operational realities. The recommendations outlined in this document reflect the expertise of sector leaders and their commitment to creating a seamless, equitable, and sustainable care framework for all Albertans.

Purpose of this Report

This report aims to inform stakeholders and policymakers about the pressing need for enhanced system navigation while highlighting innovative opportunities for collaboration, technology integration, and policy alignment to address the complexities of Alberta's continuing care landscape.

HEALTH SYSTEM TRANSFORMATION AND ITS COMPONENTS

Health System Transformation describes Alberta's ambitious effort to fundamentally redesign the healthcare system for long-term sustainability, integration, and innovation. It is guided by a vision of seamless, patient-centered care delivery in mental health and addictions, acute, primary, and continuing care. There are many interrelated components of Alberta's strategy to address continuing care challenges and position the new system for success. These initiatives must address system navigation to create a cohesive and integrated care model that minimizes confusion, reduces delays, and ensures patients receive the right services at the right time.

KEY INITIATIVES IN HEALTH SYSTEM TRANSFORMATION

1. **The MNP Facility-Based Continuing Care Report**[1] provided the evidence base and recommendations for transforming the FBCC system, highlighting issues such as system navigation, integration, and quality of life.

2. **The Continuing Care Act** legislated the foundational changes needed to implement the recommendations by merging seven Acts and Standards into a streamlined and modernized framework for service delivery. One goal of the legislation was to enable a more coherent system that supports easier navigation for clients seeking services.

3. **The Health System Refocusing** initiative operationalizes these legislative and strategic goals by restructuring governance to create a dedicated continuing care agency in alignment with broader health system transformation efforts. The intention is to facilitate integration and reduces silos, streamlining navigation for patients transitioning between medical and non-medical services.

4. **Transitioning Continuing Care** to the Ministry of Seniors, Community and Social Services reflects a recognition that continuing care spans beyond healthcare into areas like housing, transportation, and community supports. While Alberta Health retains responsibility for funding and clinical standards, the Ministry of Seniors, Community and Social Services will focus on service delivery, navigation, and social supports. The two ministries will work together in creating a collaborative model to address complex needs.

   Transitioning to a single organization focused on continuing care is anticipated to manifest many benefits including:
   - a greater emphasis on client (patient)-focused care
   - reducing silos within the health system and between medical and non-medical supports
   - streamlined transitions between care settings resulting in reduced delays
   - enhanced home and community care settings and services (medical and non-medical) to support clients' needs
   - increased opportunities to identify and implement innovative approaches in continuing care

5. **The Scope and Structure of the New Continuing Care Organization** will be guided by a 3-to-5-year vision for continuing care in Alberta, and a roadmap to support further future state design and transition and proposed. The province has contracted with Deloitte Canada to lead the research and consultation required to inform the development of the new agency. A focus on reducing fragmentation in care delivery will be critical for effective navigation.

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[1] https://open.alberta.ca/dataset/f680d1a6-bee5-4862-8ea4-e78d98b7965d/resource/22092c9c-99bb-4fee-9929-7ce06e71bbd1/download/health-improving-quality-life-residents-facility-based-continuing-care-2021-04-30.pdf

6. **A New Service Delivery Model for the Community-Based Seniors Serving sector** is in the early stages of grassroots development led by Healthy Aging Alberta in collaboration with Family Community and Social Services and other key stakeholders. The goal is to increase access to non-medical community supports for seniors to live independently and safely in the community while enjoying positive health and social outcomes. Strengthened navigation will be essential for seniors to know how to access these supports. The Alberta Association of Gerontology and the Alberta Continuing Care Association are engaged in these conversations.

7. **A 3-Year Continuing Care Roadmap for Technology Innovation** is moving forward under the collaborative leadership of the Alberta Association of Gerontology, the Alberta Continuing Care Association (ACCA) and AB Innovates. The three partners have signed a memorandum of understanding to conduct a current state assessment and recommendations related to information and technology infrastructure, public-funding models, data governance, and technology innovation/service modernization opportunities.

   By highlighting the significance of an integrated solution that fosters collaboration between acute care, primary care, and mental health and addictions, the objective is to develop a comprehensive technology strategy that mobilizes the government's transformation agenda. This approach also considers policy implications that support implementation including system navigation.

CHALLENGES IN SYSTEM NAVIGATION

System Navigation is a central theme in Alberta's health system transformation and the initiatives described, as it underpins the creation of a seamless, patient-centered care experience across care settings and services. The overarching goal is to cultivate collaboration and coherence across the broader healthcare landscape.

Alberta's continuing care system is a complex, multi-tiered framework designed to support individuals with varying care needs. While it offers diverse services through a mix of providers, it faces challenges with integration, access, and navigation.

Why is System Navigation in Alberta's Continuing Care Sector So Complex?

System navigation in Alberta's continuing care system is inherently complex due to a combination of historical, structural, and systemic factors. These complexities have far-reaching implications for patients, families, care providers, policymakers, and the broader healthcare system. The MNP Facility-Based Continuing Care Report describes the core challenges which are summarized below.

HISTORICAL CHALLENGES

Alberta's continuing care system developed without a unified strategy, resulting in fragmented service delivery. Historically, policies focused on acute care and institutional settings rather than long-term planning for integrated continuing care. The lack of investment in digital infrastructure over decades has entrenched inefficiencies and reliance on outdated, manual systems. Efforts to modernize have often been incremental, leaving gaps in both navigation and care transitions. The historical emphasis on institutional care overshadowed the development of home and community-based supports, creating further barriers for families attempting to navigate the system.

STRUCTURAL CHALLENGES

The division of responsibilities across Alberta Health Services (AHS), private operators, and non-profit organizations has led to inconsistent standards, eligibility criteria, and care pathways. Rural and remote areas face heightened challenges due to geographic barriers and limited resources, creating disparities in access and service quality. The lack of standardized case management further exacerbates these issues, as AHS retains centralized oversight while operators struggle with localized demands. Structural inefficiencies are compounded by workforce shortages, particularly in case management and care coordination roles, which hinder timely transitions and responsive care.

SYSTEMIC CHALLENGES

The absence of integrated data systems and standardized protocols hampers seamless communication between providers. This results in duplicated assessments, delays, and gaps in care continuity. Funding models do not adequately support system navigation roles or infrastructure, leaving operators and families without the necessary resources to address these challenges. The report also highlights inequities in the system, particularly for Indigenous, rural, and immigrant populations, who face barriers related to cultural competency, geographic isolation, and language differences. These systemic shortcomings create a fragmented experience for families and inefficiencies across the care continuum.

Implications for System Integration and Navigation

The historical, structural, and systemic challenges outlined in the MNP report contribute to significant delays, inefficiencies, and inequities within Alberta's continuing care system. Addressing these barriers will require coordinated policy reforms, investment in technology and workforce capacity, and the development of standardized care pathways. A focus on equity and integration will be essential to creating a navigation framework that meets the needs of all Albertans.

ACCA'S ROLE IN SYSTEM NAVIGATION

The Alberta Continuing Care Association (ACCA) has been deeply engaged in shaping conversations around system navigation within the continuing care sector. This engagement reflects the association's commitment to advocating for practical, operator-informed solutions to the challenges faced by families and providers. ACCA's proactive role has positioned it as the trusted voice of Alberta's continuing care sector, uniquely qualified to collaborate with the government on improving navigation.

Recent Milestones

At the June 18, 2024 Member Meet, the Honourable Jason Nixon, Minister of Seniors, Community and Social Services, outlined significant structural changes planned for Alberta's continuing care system. He referenced the success of the Edmonton Navigation Centre in connecting individuals with supports and forecasted a similar transformation for continuing care navigation. The inclusion of navigation as a priority in the discussion underscored its critical role in the government's vision for health system improvement.

On October 16, at the ACCA 2024 Annual Conference, the Honourable Premier Danielle Smith chose the association's venue to announce a historic shift in governance: responsibility for continuing care would transition from Alberta Health to the Ministry of Seniors, Community and Social Services. This announcement signalled a new era of collaboration among public, non-profit, and independent care providers to enhance navigation and improve care transitions. Premier Smith's decision to make this announcement at the ACCA's event demonstrates the government's recognition of the association's leadership and influence within the sector.

On October 17, 2024, the Honorable Ministers Adriana LaGrange, Jason Nixon, and Dan Williams participated in a plenary Fireside Chat conversation at the ACCA Annual Conference. The three Ministers outlined plans for creating a dedicated continuing care agency to become operational by spring 2025. This new organization will focus on delivering seamless services through a user-friendly online platform, enhancing workforce capacity, increasing care options, and improving quality.

SIGNIFICANCE

The active engagement of ACCA in these pivotal discussions, combined with the government's decision to use ACCA-hosted venues to announce major policy shifts, demonstrates the association's central role in the continuing care sector. ACCA represents the collective voice of providers and is a natural partner for the government in addressing and navigating the complexities of system transformation. ACCA's deep understanding of operational realities ensures that its collaboration with the government can translate into practical, effective solutions.

INSIGHTS FROM CONTINUING CARE OPERATORS

On November 25, 2024, ACCA convened a Member Meet to continue the navigation conversation. Following a panel presentation on balancing technology with a human-centered navigation approach, a facilitated discussion produced actionable recommendations to simplify access, improve transitions, and address system inefficiencies.

Below is a synthesis of the critical points raised by continuing care system operators, grouped into thematic categories for clarity. Each section reflects the depth of their expertise and focuses on actionable recommendations.

1. Transition Challenges and Standards

- Non-Complex Operations: Standards for non-complex facilities and those with low bed counts need to be better defined.
- Home Care Expansion: Increase funding and operational areas to support aging in place effectively.
- Complex Care Standards: Develop clear standards for complex care within home models, including innovations in technology and assessments to support complex clients.
- Transition Beds: Establish short-term transition beds, especially in rural areas or underused facilities, to bridge gaps in care. Investigate underutilized facilities for potential repurposing.
- System Transparency: Improve visibility into system-level issues, such as tracking "bed blockers," to identify barriers and ensure smoother transitions.
- Collaboration with AHS: Strengthen partnerships between AHS and operators to understand real demands and improve care transitions for residents with specialized needs.

2. System Fragmentation and Integration

- Portability Issues: Small-home models and private pay operators lack alignment for continuity of care, particularly during transitions between acute care and continuing care.
- Diagnostic Flexibility: Allow occasional hospital-level diagnostic testing for residents directly in continuing care settings to reduce care delays.
- Standardization Across Sites: Align standards and practices across hospitals, care facilities, and rural networks to eliminate operational silos.
- Improved Support Systems: Address complexities related to mental health, smoking, and social challenges to make transitions more seamless.
- Fraser Health Pathways Model: Explore tools like Fraser Health's pathways to improve access to allied health professionals (e.g., social workers, therapists) and streamline transitions.

3. Technology and Infrastructure

- Funding Needs: Secure funding for technology upgrades, including electronic health records (EHR) and reliable Wi-Fi access, particularly in rural areas.
- Interoperability: Implement a unified technology system across care sites to streamline communication and reduce resource demands on staff.
- Automation: Increase automation to reduce manual processes, freeing staff for higher-priority tasks. Adopt the "80/20 focus" approach to prioritize key resources.
- Future Planning: Adopt a long-term roadmap for technology integration, ensuring sustainable upgrades and reducing redundancy.
- AI Tools: Explore AI solutions like chatbots and language learning models to assist with navigation, financial planning, and operational efficiencies.

4. Access and Navigation

- Uncoordinated Services: Many services remain disconnected, forcing families to navigate multiple doors for access.

- Real-Time Tools: Leverage My Alberta Health to create e-forms and share real-time data on care options, availability, and service wait times.
- Local Access Barriers: Address transportation challenges, particularly in rural areas, by enhancing local accessibility.
- No Wrong Door: Develop a navigation system where all inquiries lead to correct resources, supported by knowledgeable, multilingual staff.
- One-Stop Shop for Healthcare: Investigate creating a centralized "one-stop shop" model for seamless healthcare access and navigation.

5. Patient and Family Support

- Palliative Care: Emphasize human-centered approaches, aligning staffing adjustments with resident needs.
- Education and Awareness: Educate caregivers about available options and involve families in transparent assessments. Ensure assessments are honest and family inclusive.
- Community Involvement: Partner with local organizations to provide wrap-around services, such as transportation, meal supports, and home maintenance.
- Private vs. Public Options: Ensure families are aware of both private and public care options, creating fairness in navigation systems.
- Family Incentives: Provide tax benefits to encourage families to support aging in place and multigenerational living arrangements.

6. Equity and Rural Focus

- Rural Wrap-Around Supports: Pilot community hubs combining healthcare, transportation, and social supports to address rural gaps.
- Subsidies: Increase financial assistance for low-income families in underserved areas.
- Tailored Supports: Offer interim care and untapped capacity, such as enhanced home and palliative supports, to bridge long wait times.
- Addressing Rural Needs: Ensure rural areas receive equitable attention in service delivery, technology upgrades, and staffing.

7. Policy and Legislative Challenges

- Administrative Burden: Simplify licensing, compliance, and reporting processes to reduce excessive red tape for operators.
- Case Manager Roles: Transition AHS case managers into staffing teams within supportive living homes, aligning them with funding models.
- Privacy and Data: Consult with privacy regulators to streamline data-sharing policies and eliminate unnecessary requirements for operator personal information.

8. Mental Health and Behavioral Support

- Service Expansion: Move beyond medication-focused interventions to include counseling, peer support, and social programming in LTC and supportive living.

- **Behavioral Beds**: Expand transitional beds and specialized programs for residents with complex or unsafe behaviors, reintegrating them when appropriate.
- **Missed Cases**: Address gaps where individuals with mental or physical health needs fall through the cracks.

9. Simplified Processes and Education

- **Interactive Directory**: Create a user-friendly care directory with real-time updates, public and private funding options, and facility details.
- **Provincial Pathways**: Standardize care pathways to improve access to allied health professionals, such as social workers and therapists. Build upon models like Fraser Health Pathways.
- **Public Awareness**: Conduct education campaigns to improve understanding of care levels and funding options available to residents and families.

10. Transparency and Data Access

- **Real-Time Dashboards**: Develop integrated dashboards for providers to track transitions and care availability across settings.
- **Cultural Sensitivity**: Address differences in language and dialects to improve communication and ensure inclusivity.
- **Liberate Data**: Allow families and providers better access to centralized, timely data to facilitate decision-making and transparency.

CONCLUSION

The insights provided by continuing care system operators highlight a need for systemic improvements across multiple areas, including standards, funding, technology, equity, and policy alignment. These recommendations emphasize the importance of collaborative efforts between operators, families, and policymakers to create a navigation system that meets the needs of all Albertans effectively. By addressing these challenges, Alberta can build a seamless, patient-centered, and sustainable continuing care framework.

THE OPPORTUNITY TO IMPROVE SYSTEM NAVIGATION

Alberta’s ongoing health system transformation presents a pivotal opportunity to address long-standing challenges in continuing care system navigation. By aligning navigation reforms with broader healthcare modernization efforts, Alberta can create a more integrated, equitable, and efficient system that improves patient outcomes and system sustainability.

The current moment presents a critical opportunity to improve navigation in Alberta’s continuing care system, driven by a confluence of demographic trends, evolving care priorities, and Albertans’ expectations.

RECOMMENDATIONS FOR COLLABORATIVE ACTION

ACCA is uniquely positioned to collaborate with government in addressing the complexities of system navigation. Frontline insights provide a vital lens to evaluate and refine navigation strategies. ACCA's contributions can ensure that the Alberta Government's navigation system is co-created to be **practical**, **responsive**, and **aligned with real-world needs.** By acting as a trusted partner, ACCA can bridge the gap between policy and operations to improve access, transitions, and care quality for all Albertans.

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