Fraser Health’s Home is Best™ Philosophy

Changing Culture and Transforming Practice through Community and Primary Care Integration

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B.C.’s Commitment

All health authorities participating

**GOAL:** “British Columbians have the majority of their health needs met by high-quality community-based health care and support services”

... to be achieved through the creation of an integrated primary and community care system
The Big Shift

...keys to our success

➡️ From an acute to community services
➡️ From hospitals-first to ‘home-first’
➡️ From independence in your work to collaboration
➡️ From silos to integration

➡️ Strong Leadership
➡️ Appropriate and effective workforce
➡️ Integration through team based service delivery
➡️ Service coordination
Meanwhile: FH needs beds for acutely ill patients:
- 200 ER Admits/day waiting

Average 260 patients/day waiting for a different level of care occupy acute beds. Most are seniors
We’re Listening

“Nothing about me without me”

Seniors tell us:

“We want to stay in our homes – to sleep in our own beds, eat at our own tables, watch TV in our favorite chairs. And we’re willing to face some risks to do that.”

We’ve responded: With a new system-wide approach to ensure timely transitions to the right place for each person in our care.
Taking Action

A multi-pronged, integrated approach across the system

... to create more timely flow of patients to the right care.

- Address seniors’ desire to go home
- Improve access to beds for acutely ill
- Better utilize residential beds for those needing 24/7 care
System-Changing Strategies

ENABLERs = System changes and/or initiatives

Goal of all: to improve smooth, timely movement of patients and clients to right care

Simultaneous changes across all programs, guided by the ‘Home is Best’ philosophy
Enabler # 1: Changing traditional thinking

Culture Change

All initiatives line up under “Home is Best”

Understandable concept for staff, physicians and the public

Sending patients home safely with appropriate supports is acceptable – resonates at a personal level

Staff and families feel more confident the system will keep patients safe after discharge home.
Home is Best

FH is pioneering this philosophy in BC, across the system

 Longer hospital stays = decreased mobility, confusion, risk of infection

 Home is the best place to recover and manage conditions, with appropriate supports

 Most seniors want to live at home

 Residential Care, last resort
Enabler #2: Organizational Structure

‘Program Management’

For system planning:
New horizontal, regional program structure supports collaboration and integration across traditional boundaries

⇒ All Programs at the table

For timely patient transitions:
Enables flow across traditional boundaries

⇒ Transitions to the right place for the patient
Enabler #3: Organizational Structure

Care Management

Current BC Model
• Service-focused
• Single Sector
• One-to-one home approach
• Focus on eligibility/ interventions
• Case Manager as a defined role
• Broker model
• Reactive

Home Care in Integration
• Client focused
• Partnerships – Family physician, multiple disciplines / team; community
• Enhance chronic disease mgt
• Proactive: improve self management
• Improve client experience
• Population-approach
Enabler #4: Home Health + Primary Care Partnership

Integrated Health Networks

Home Health / GP Partnerships

- Case manager assigned to GP practices
- Support LTC patients and high ED and hospital users
- Comprehensive, proactive care management with GP

Closes the loop with upstream benefits: avoidance of future ED visits and hospitalization
PATH Units

‘Patient Assessment and Transition to Home’

Most-complex non-acute patients co-horted on specialized units: all hospitals, 230 beds

Care delivery model within acute care that best meets the needs of this population; Quick Response Case Managers coordinate discharges.

PATH teams model the Home is Best philosophy.
Enabler #6: Home, not Residential Care

Home First Strategy

Acute Care teams are educated to consider ‘home’ as the first option instead of residential care.

- Patients to try living at home with supports, if appropriate
- Case Manager monitors to ensure the patient is managing safely at home
- If care needs can no longer be safely met, patients are assessed for assisted living or residential care.
Home First Enrolment & Program De-Registration to Residential Care

- Existing Clients*
- New Clients
- De-Registered Clients **

2011/12 - 2012/13
Enabler #7: Avoiding Acute Care Admissions

Quick Response Strategy

Emergency Departments

- Prototype strategy for admission avoidance
- Case Managers in the ERs
- Work with Geriatric ER Nurses
- Coordinated appropriate supports to allow discharge home and avoid hospital admission
Avoiding Admission

Number of ER patients not admitted due to Quick Response Case Manager intervention

Target = 46/FP
Enabler #8: Better Chronic Disease Management

Breathe Well at Home Program

Giving patients the tools to better self manage their COPD

- Early recognition of flare up,
- Early implementation of flare up plan, pre authorized meds
- Better self care – prevent flare up and delay progression
- Decrease utilization acute care services
Enabler #9: Realigning Resources

Growing Home Care Teams

Still a work in progress

Reducing waitlists and meeting demand

Reinvestment of dollars into home health services has resulted in more:

➔ Home care nurses, case managers, home support workers

➔ Hours of home care/mo. Increased by 16%

➔ Community clinics for wound care
Organizational Trends

- Positive patient/family feedback
- Positive staff feedback/actions

Learnings

Collaboration across programs and traditional boundaries: A key requirement for success
Questions?