

Fraser Health's Home is Best™ Philosophy

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***Changing Culture and
Transforming Practice
through Community and
Primary Care Integration***

Lynda Foley, Executive Director



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”

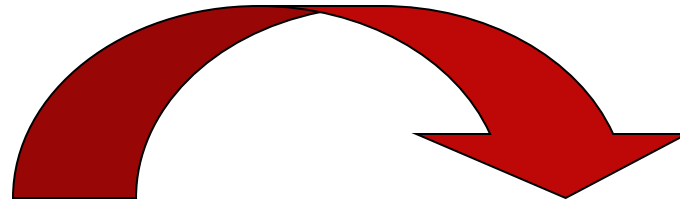


... to be achieved through the creation of an integrated primary and community care system

The Big Shift

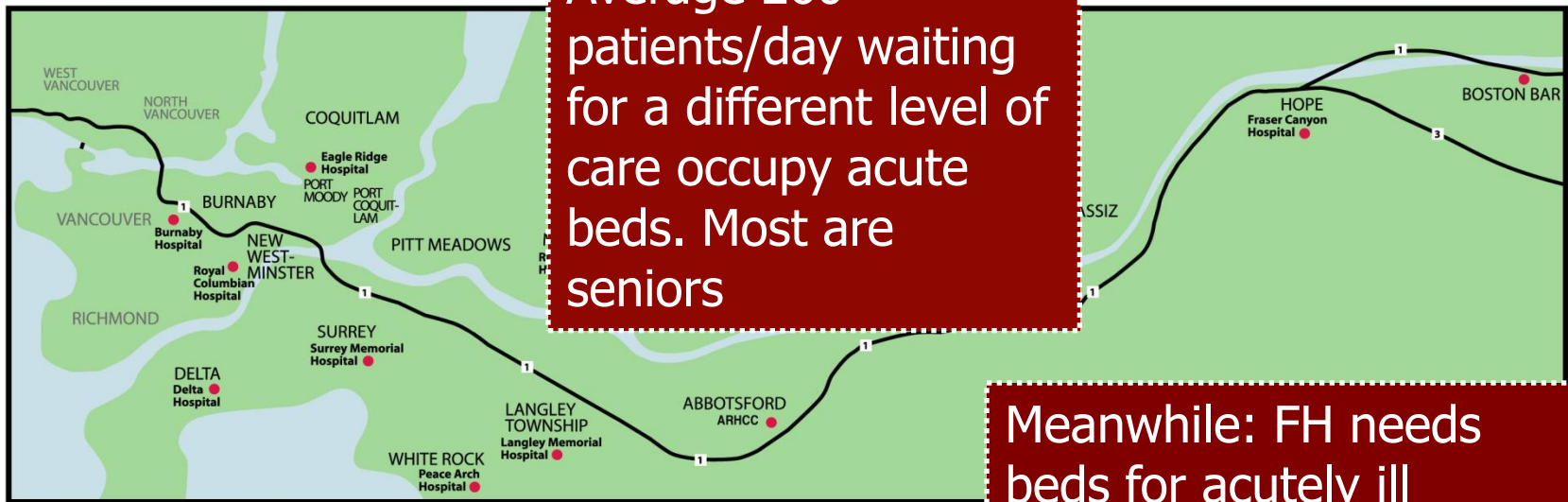
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...keys to our success

- 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

The Current State



Meanwhile: FH needs beds for acutely ill patients:

- 200 ER Admits/day waiting

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:

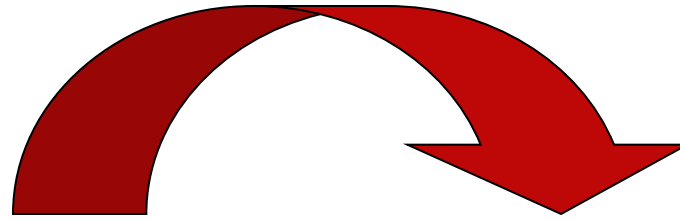
Enables flow across traditional boundaries

→ *Transitions to the right place for the patient*



Enabler #3: Organizational Structure

Care Management



New Approach

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

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‘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

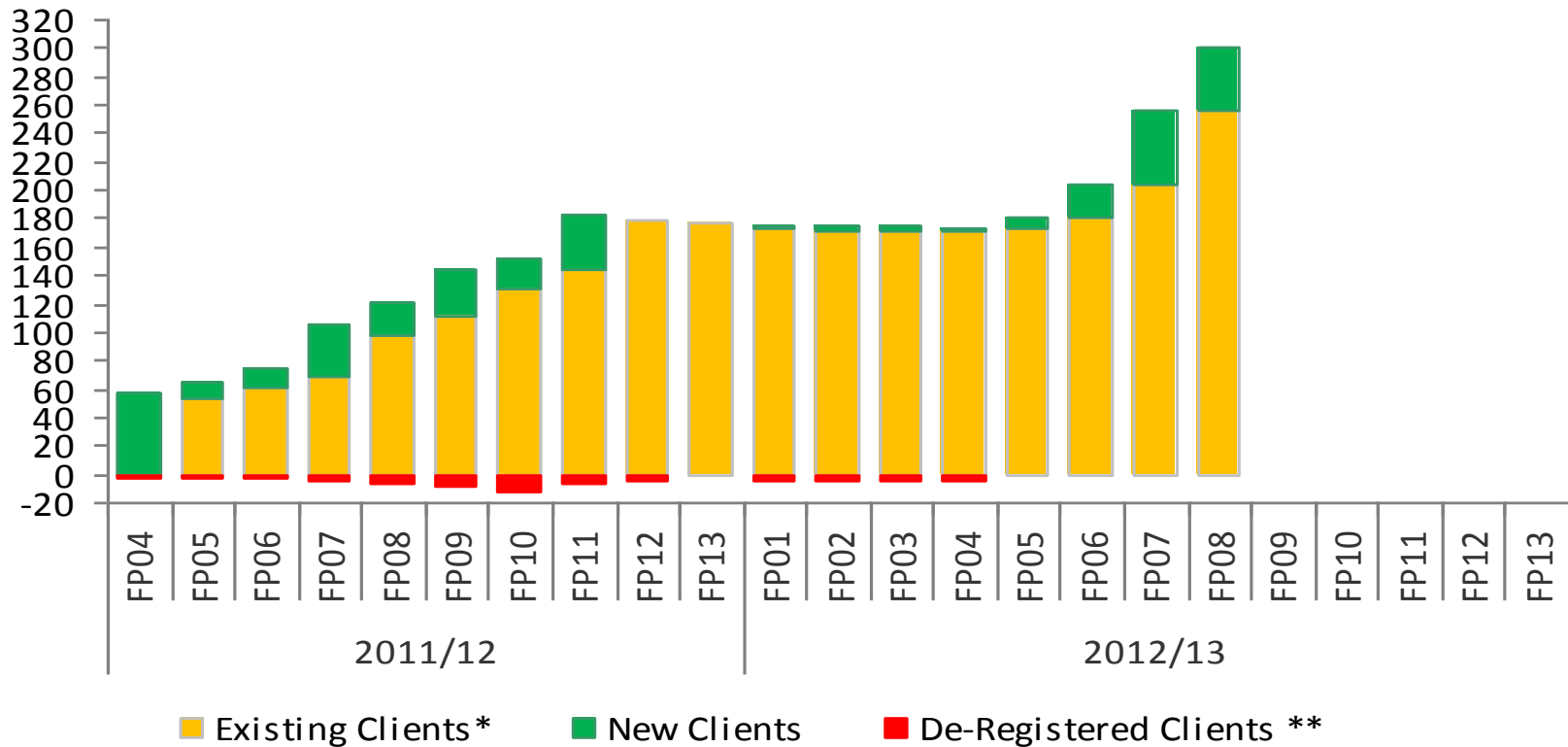
Acute Care teams are educated to consider 'home' as the first option instead of residential care.

- 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 Progress

Home First Enrolment & Program De-Registration to Residential Care



Enabler #7: Avoiding Acute Care Admissions

Quick Response Strategy



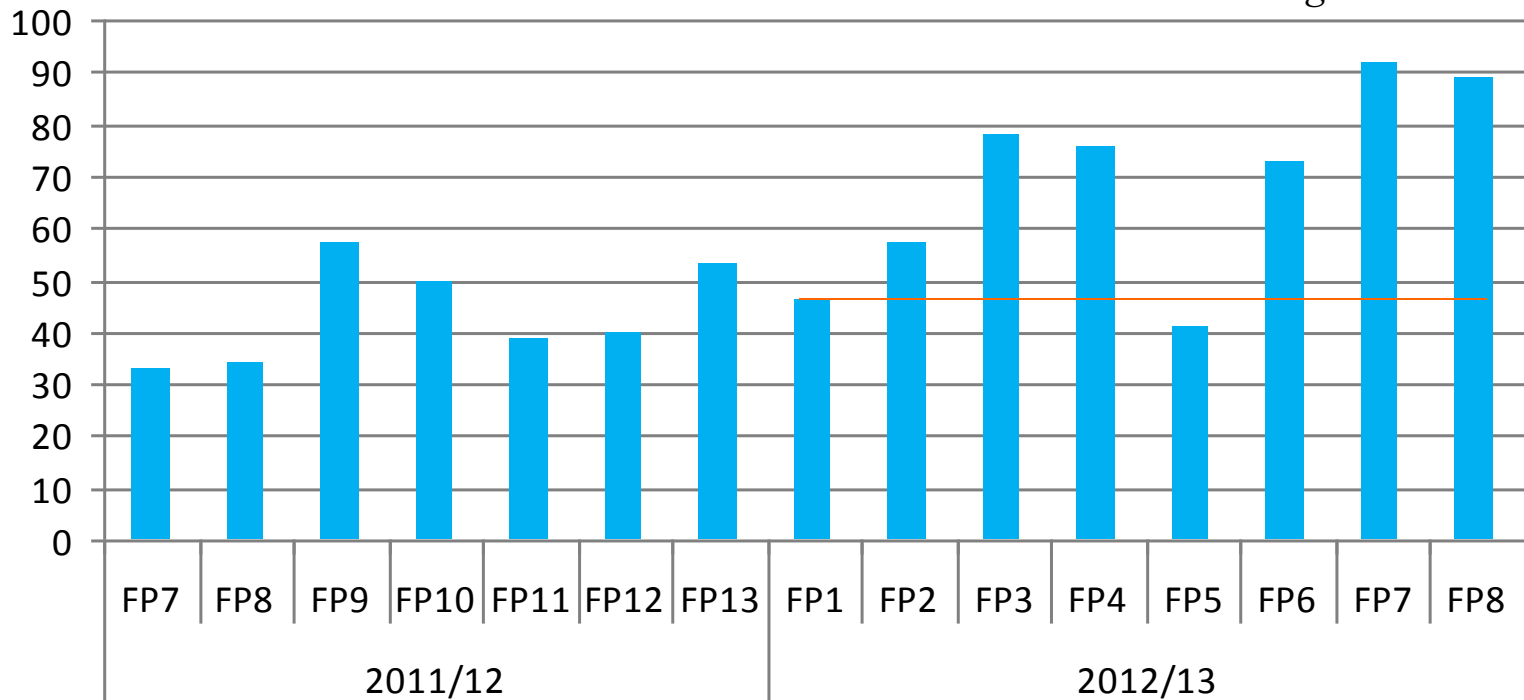
Emergency Departments

- 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



Learnings

Organizational Trends

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

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



Questions?

