INTEGRATED PRIMARY AND COMMUNITY CARE

MONTHLY STATUS REPORT (Section 1 of Quarterly Report)

Health Authority : Vancouver Coastal Health	**Reporting Period: November 16 – December 15, 2011**
Completed by: Venie Dettmers	**Submitted to MOH: December 23, 2011**

Summary of Major Progress and Key Accomplishments Since Last Report

Macro (across HA):

- Care Management
  - Implementation of the provincial Care Management Strategy will be prototyped in Powell River. Plan for the rollout of the strategy is being developed by the Care Management Lead and the VCH Collaborative Practice Team.

- Enablers
  - Jointly developed with Fraser Health an IPCC roadmap for integrated care that shows the outcomes to be achieved, linkages between outcomes and the initiatives that contribute to the outcomes.
  - Selection process for the position of Regional Evaluation Lead has been completed. A candidate has been selected and has accepted he position with a starting date in February.
  - Updated the IPCC Communications Plan.
  - Updated the description of roles and responsibilities of regional team members and local change leads.
  - Explored the feasibility of generating a report from PARIS that will list patients of a GP who are receiving home health services.
  - Summary of the Community Engagement Forum on IPCC and Health literacy now available to support health literacy within IPCC and inform the patient voice across all CBSDAs

Meso and Micro (for specific populations or patient groups; by CBSDA):

1. Powell River

- The first IPCC Newsletter was produced and distributed to GPs and VCH community staff.
- Single referral for form for home and community care is being developed.
- Alignment of Mental Health staff with GP being planned.

2. North Shore

- Testing of case conferencing between GP and case manager has started with the first case conference successfully conducted. Three case managers with eight clients and their GPs will continue to test case conferencing until January, 2011.
- Other case conferencing has occurred in the past 6 months, with two GPs on 10 clients by IPCC case manager on the North Shore.
- Working groups established for Communications, Change Management, Process Redesign, Community Capacity Building.
- Steering committee revisiting issues/challenges to help with problem statements and project charter.
- Patient journey map planning underway.
- Care Management Lead met with Home and Community Care Directors and managers to discuss

further the implementation of the provincial Care Management Strategy.

3. Richmond

- Reviewed the future state map developed from the November 4 workshop along with improvement ideas. IPCC committee members will assess improvement ideas in terms of value and effort to identify Quick Wins, Gems, Strategic and Don't Do ideas.
- Started the pilot testing of the Screening-Tracking Tool to case-find and assess for frailty people in the target population. Those found appropriate for referral to case management will be referred to Continuing Health Services and those who are fit or well with treated comorbid disease will be linked to community supports.
- Standard Referral Form completed; pilot testing of the form with Richmond IPCC Family Physicians.
- Individual/group patient interviews are being conducted. Patient inputs will be captured on issues/challenges of current process as well are improvement ideas for the future.
- Established baseline data for process measures and KRA 3 indicators for frail elderly target population (age 80+).

4. Pemberton in Sea-to-Sky

- Since the focus of the IPCC is on the collaboration of services between the Mt. Currie Health Centre, Pemberton Health Centres and Southern Stl'atl'inx Health Centre, the December 9th working group meeting was held in Mt. Currie Health Centre and hosted by interim director. The director of the Stl'atl'nx Health Centre was invited and expressed great interest in the collaboration of services however was unable to attend this meeting. .
- Working group continued to identify and discuss issues and needs of the target population.

5. Downtown Eastside Vancouver

- Working group reviewed profile of patients who are known to VCH GPs/NPs and who made 10 or more visits to St. Paul's Hospital Emergency Department.
- Privacy requirement of sharing patient info between ED and GPs/NPs is being explored.

Key Issues, Dependencies and Mitigation Strategies:

Issues/dependencies/barriers	Mitigation Strategy:
• Continuous engagement and buy-in of stakeholders.	Ongoing engagement using various forms such as: *Open House orientation, status reporting and hearing stakeholder issues * Hearing their voices and issues during mapping sessions and meetings. * Holding staff orientation and Question & Answer sessions.

• Local ownership of IPCC	Local leads to take lead in planning and implementing activities with support from regional team.
• Implementation of parallel initiatives related to IPCC such as the provincial care management strategy and Patient Focused Funding projects.	Roadmap of outcomes and initiatives developed; opportunities for consolidation and coordination will be highlighted.
• Privacy issue and sharing of patient information between GP and home health staff.	Clarify appropriate methods under the privacy law and recommend that there be a VCH policy
• Clear understanding and support of Senior Executive Team for IPCC initiative	Regular presentation at SET meetings.

Successes and Lessons Learned:

- Early engagement of all stakeholders is important in building buy-in for project.
- Working on "quick wins" is needed to keep stakeholders engaged.
- Mapping sessions are effective in engaging stakeholders in generating improvement ideas.
- Communication and interaction including face to face meetings are essential for integration/collaboration in service delivery to occur.
- Local managers/leaders leading IPCC activities such as agenda setting, mapping and meeting with stakeholders encourages local ownership of the initiative.
- Case conferencing has a recognized value in bringing GP and case manager together.

QUARTERLY REPORT (Section 2) –September 16 to December 15, 2011

	Community Based Service Delivery Areas	Communities included in CBSDA	Total Population of CBSDA	Version #[1] /stage planning & implementation	Division *-In place -In Progress -Not started*	# Family Physicians engaged (re ated to vers on/ terat on)	CSC *-In place -In Progress -Not started*	Target Population(s) *Name (i.e. frail elderly – home health) & Case definition*	# People in the Target Population *(estimate based on case definition - denominator)*	# Patients receiving new or redesigned services *(cumulative # of unique patients)*	% Reach[2]
1.	Powell River	Powell River	19,733	Planning & testing improve ment	In place	11 in planning/ testing; 20 attended Open House	In progress	Very High & High morbidity with cardio-vascular disease or MHSU;	1,722	19 in testing of case conferencing between GP & Case Manager; 300 patients received services from Chronic Disease Nurses in GP practices	
2.	North Shore	North Vancouver & West Vancouver	186,776	Planning & testing improve ment	In place	7	In place	Very High & High morbidity	17,906	11 in testing of case conferencing between GP & Case Manager; 473 patients continue to receive service from Chronic Disease Nurses in GP practices*	
3.	Richmond	Richmond	189,027	Planning	In place	15	In progress	Frail elderly: age 80+ and 70-79 with Alzheimer/ dementia	7,178	621 patients continue to receive service from Chronic Disease Nurses in GP	

[1] *Version # indicates progress using incremental improvements; if your HA uses a stages of implementation framework, please indicate that status/iteration)*

[2] *Reach = number of patients receiving services (cumulative count)/ number of patients in target population (actual as per case definition, or estimate)*

* Chronic Disease Nurse-GP team under the IHN model will be combined with IPCC

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 2) –September 16 to December 15, 2011

										practices*	
4.	Howe Sound	Pemberton Squamish Whistler	33,458; Pemberton on y=5,118	Planning		2		Population in Mt. Currie Reserve and Southern Stl'atl'inx.	1,800	At least 24 patients from Indian Reserve areas received care from Chronic Disease Nurse in GP practice	
5.	Vancouver - Downtown Eastside (DTES)	Downtown Eastside Core	61,242	Planning	In place	2	In place	Complex marginalized population	8,000	700 patients continued to receive services from the primary care outreach team in 16 Single Room Occupancy hotels	
6.	Vancouver - Except DTES	All LHAs except DTES	568,663		In place		In place			621 patients continued to receive service from Chronic Disease Nurses in GP practices*	
7.	Sunshine Coast	Sunshine Coast	28,936								
8.	Bella Coola Valley and Central Coast	Bella Coola Valley & Central Coast	4,290								

* Chronic Disease Nurse-GP team under the IHN model will be combined with IPCC

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QUARTERLY REPORT (Section 3)

	Community Based Service Delivery Areas **2011/2012**	Collaborative Services Committee priority issues/ <List-may coincide with CSC agendas or IHN Steering Committee Agenda> Below are VCH Local IPCC Steering Committee agenda/issues:	Describe planned new or redesigned services (and % implemented) < describe **key integration** activities that are being prototyped; **include numbers of other providers** such as case managers, nurse practitioners etc >	Patients as Partners Specific examples of how this service delivery element is being embedded by CBSDA i.e. Patient/community partner on CSC; training etc	Care Planning - Coordinated / Shared Care Plans (key elements or, operational definition ; # shared care plans per GPSC billing fee)
1.	Powell River	▪ Sharing of information between GPs and VCH home health & mental health teams ▪ Timely communication ▪ Shared care plan – eventually electronic ▪ Building community partnerships	▪ Case conferencing between GPs and case managers to enhance communication and care coordination ▪ Identification of top 20 ED users and follow-up with GPs	▪ Patient involvement planned in the community such as patient representation in local IPCC Steering Committee ▪ Formal orientation of patient representatives before involvement in Steering Committee ▪ Various ways of capturing patient voice such as patient survey, patient journey mapping	Care planning done as part of GP-Case Manager case conferencing. Possible measures include: ▪ Patients in the target population who have a care plan based on GP billing ▪ Patients in the target population who have a care plan in VCH's PARIS (Primary Access Regional Information System)
2.	North Shore	▪ Proactive identification of high risk patients ▪ Linking GPs and VCH home health & mental health teams ▪ Building community partnerships	▪ Proactive case finding protocols ▪ Intensive case manager aligned with GP practice ▪ Case conferencing between GP and case manager to enhance communication and care coordination	Same as above	Same as above
3.	Richmond	▪ Proactive frailty assessment of all people age 80+ ▪ Improving referral and service delivery processes between GPs and VCH	▪ Proactive frailty screening of people 80+ ▪ Standard referral form for all home health services ▪ LTC 1 assessment report given to GP ▪ Case conferencing between GP and home health care provider	Same as above	Same as above

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 3)

		home health teams ▪ Improved communication and interaction of among team of care providers			
4.	Howe Sound - Pemberton	▪ Review of integration practices in current system ▪ Integration between services at Pemberton Health Centre and Mount Currie and Southern Stl'atl'inx Health Centres	Discussion ongoing	Same as above	
5.	Vancouver - Downtown Eastside (DTES) Core	▪ Defining the target population ▪ Building on current initiatives to integrate services between VCH GP clinics and home health & mental health teams ▪ Targeting high ED users and improving primary and community care delivery	Discussion ongoing	Same as above	

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

INTEGRATED PRIMARY AND COMMUNITY CARE

QUARTERLY REPORT (Section 1)

Health Authority : Vancouver Coastal Health	**Reporting Period: April 1 to June 30, 2012**
Completed by: Venie Dettmers	**Submitted to MOH: June 25, 2012**

Summary of Major Progress and Key Accomplishments Since Last Report

Macro (across HA):

- **Accelerated Integrated Primary and Community Care**
  The following proposals have been approved for Accelerated IPCC funding:
  - Home is Best An initiative to provide an enhanced home based service to clients who would otherwise be moved to residential care. Care is provided by an interdisciplinary team with the following focus: intensive care management; and an enhanced mix of community-based services designed to meet the needs of clients with multiple, complex and interacting chronic diseases and/or social and environmental factors.

  - Acute Home Based Treatment (AHBT) A comprehensive regional strategy aimed at providing home-based treatment for mental health and addictions clients as an alternative to hospitalization. The AHBT team consists of psychiatrists, clients, families, GPs and nursing staff supported by social workers, counsellors, or rehabilitation professionals as required. This team follows clients and provides intensive short-term treatment in the clients' home.

  - Early Supported Discharge This program, in collaborative partnership with GPs, will include an interdisciplinary community reintegration team that supports patients through an early discharge from acute care. The team will provide short term rehabilitation for up to three months that includes: coordination, education, and provision of self-care management education and support to patients and caregivers to enable them to have knowledge and skills needed to manage their chronic condition.

  - Assertive Community Treatment (ACT) A client-centered, recovery-oriented mental health service delivery model. The ACT team is mobile and delivers services in community locations to enable clients to continue to live in their community. This service is provided 24 hours a day by a multidisciplinary team, including a GP, with a low client to provider ratio.

  - Care Management This is a phased project over three years aimed at redesigning VCH Home Health services to align with the provincial care management strategy and integrate teams with primary care in each community.

- **Care Management**
  Funded under the Accelerated IPCC funding, the Care Management project has two components: Care Conferencing for the clients with complex conditions; and Telephonic Care Management for clients with Chronic Health Conditions with self management capacity. The details of the proposal and its implications have been discussed with management of each Community of Care (COC). The discussion has been around starting with Care Conferencing at Powell River, Sunshine Coast and Vancouver. At Powell River, the leadership team continues to work with the VCH Collaborative Practice team, a steering committee established, and a draft time line is in place for the Home Health Redesign. At the North Shore, case managers are case conferencing with the GPs.

- **Patients as Partners**
  - Patient role and Aboriginal role description for steering committees were developed.
  - Participation of eight public members from VCH area in the provincial IPCC learning session was facilitated.
  - Inputs from patients/community partners in improvement work in the following communities was facilitated:
    - North Shore Current state map of home and community care intake process
    - Pemberton Sea to Sky BEST transportation meeting
    - Richmond Medication card for patients

- **Evaluation**
  - Evaluation plans have been developed for the following pilot projects (6 out of 15) including surveys instruments and data capture processes:
    - Integrated Care Process for High ED users Downtown Eastside
    - Case Management GP conferencing North Shore
    - Complex Care Navigator North Shore
    - Standard Referral Form/LTC 1 Form Spread Richmond
    - Communication Strategy Richmond
    - Medication Management Richmond
  - Evaluation approach is being worked out for IPCC community partnership projects and the Aboriginal IPCC initiative group.
  - Assistance was provided with the evaluation section of Accelerated Funding proposals.

- **Provincial Learning Session**
  The regional team and leaders from Integration Communities participated in the June 14-15 provincial learning session in Vancouver. The team prepared and shared a presentation on VCH integration experience. Cheryl Rivard, our Patients as Partners lead played a key role in the development and implementation of the PechaKucha format Community Partner Perspective presentations. Carole Gillam, our Executive Director, participated in a panel discussion on "Innovating to Manage Change".

Meso and Micro (for specific populations or patient groups; by CBSDA):

1. Powell River

- The Powell River IPCC Committee:
  - Held a Reflection meeting on May 1 to assess overall progress and status of initiatives.
  - Revisited and updated the Terms of Reference. A new rotation of co-chairs at the steering level has begun with a local GP sharing the duties with a VCH manager. Meetings are now scheduled to be quarterly rather than monthly.
  - Further discussion will be conducted on the Steering Committee structure for Powell River.

- The following improvements are being implemented to achieve integration of care:
  - **A VCH mental health (MH) counselor assigned to work in a physician-led Methadone clinic** - MH counsellor continues to meet clients/patients within the Methadone clinic and the number of people seen is double what is normally seen in the same time period. The specific population suffering mental illness being seen at the Methadone Clinic are being served by an

integrated team approach.

- **A VCH Home Care Nurse assigned to work at the GP office** (2 hrs every 2nd Wednesday) This initiative continues to develop a more integrated and trusting relationship between Home Care Nurse and GP. To date, 12+ patients have been involved within this shared care approach; at least 30+ other "potential" clients/patients have been discussed by the GP and HCC RN. Discussion around spread and evaluation has begun.

- **"At Risk" users/presenters to the ED** The ED initiative has evolved to focus on "At Risk" users/presenters to the ED rather than just high users. Next steps are looking at a systematic approach of case management for people that would be better served with more coordinated care.

- **Connecting Pregnancy Program** - The program aims to develop a rural model of interdisciplinary primary maternity care. A group of six to eight women and their partners attend 9 group sessions over 18 weeks (every other week). It is co-facilitated by a family physician and public health nurse. The program has three components: Assessment, Education and Pregnancy Support and is currently in its third uptake.

- **Community partnership** projects funded in 2012/13 to support people with chronic conditions or mental health/substance use problems are the following:
  - Humble and Hearty Workshop - cooking workshops for participants on low income, use the food bank and are looking for new healthy meal ideas.
  - Monday Brunch - weekly brunch provided along with community health education.
  - Promoting Community Wellness - weekly recreational programs such as walking and yoga for people dealing with mental health conditions.
  - **B**uilding **R**ecovery of **I**ndividual **D**reams & **G**oals through **E**ducation (BRIDGES) program taught by consumers for consumers to empower people with tools that will help them on their journey to recovery.

2. North Shore

- The North Shore IPCC Committee:
  - Defined problems based on focus groups to develop an updated IPCC Project Charter.
  - Continues to provide direction and oversee the progress of the following working groups: Communications, Evaluation, Community Partners, and Change Management & Staff Development.

- The following improvements are being implemented to achieve integration of care:
  - **Complex Care Navigator supporting GPs** - The complex care navigator based in the VCH day clinic continues to see steady increases in referrals from GPs particularly since the production of a YouTube video posted on the Division of Family Practices' website and was shown to a group of 50+ physicians who participated in the Division's annual general meeting in May. The video explains the chronic disease navigator role and has been extremely well received by the physicians who have viewed it as it is short (4 minutes) and humorous and uses cameo appearances by well know physicians to get the message about this service across. Since the beginning of winter 2011/2012, 39 clients were served and 14 GPs were involved. These clients have complex medical and psycho-social needs and multiple providers.

- **GP and Case Manager case conferencing** - With the objective of collaborating on client care, case conferencing in person or over the phone between Home and Community Care (HCC) Case Managers and GPs continues. To date, 16 GPs and 11 out of the 17 Case Managers have held case conferences on 27 clients. Positive verbal accounts have been received. A resource folder was created in the case managers' VCH shared drive with step-by-step flow, forms and other information. The plan is to have for all case managers trial case conferencing.

- **Home and Community Care intake redesign** - The current state mapping of Home Health Intake is completed and future state mapping is scheduled for June 20, 2012. There were numerous opportunities identified already to improve the flow. Two physicians actively participated in the mapping as did two community representatives.

- **Smart Phone App** - The smart phone app which will contain information about programs and services on the North Shore that physicians and their MOAs will find valuable is in production with partial funding for the development component. Preliminary viewing has demonstrated the ease of access and searching for information including locations.

- **Community partnership** projects funded in 2012/13 to support people with chronic conditions or mental health/substance use problems are the following:
  - Counseling Service - individual and group counseling for individuals experiencing mild to moderate depression and chronic illness.
  - Golden Circle - outreach program for frail and/or isolated seniors to provide health, wellness and socialization opportunities to help improve quality of life.
  - Seniors Peer Support Volunteer Program - offers one-on-one emotional support, guidance regarding life changes and challenges, as well as provide resource information.
  - North Shore Keep Well - an exercise and wellness program for mobile seniors to encourage and help older adults to keep well by leading active and independent lives. The program includes one hour of exercise followed by blood pressure checks and health coaching, massage, speakers and social times.
  - First Link a first response strategy for people newly diagnosed with dementia and their families. It includes proactive outreach, information and connections, and planned follow-up.

3. Richmond

- The Richmond IPCC Committee:
  - Spent time reflecting on one year's work on building an IPCC system. Members provided positive thoughts on their experience and also recognized that leadership from Richmond Home and Community Care is effective in helping to shape IPCC work.
  - Continues to provide direction and oversee the progress of the following sub-working groups: Screening-Tracking Took, Medication Management, One Care Coordinator, and Senior's Community Resource List and Key Community Agency Partnerships.
  - Looked more closely at the role of the Chronic Disease Nurse to more effectively use the role around the care of complex patients, similar to the Complex Care Navigator in the North Shore.

- A communication plan has been developed to identify strategy and tools to keep Home and

Community Care (HCC) staff informed and engaged in IPCC initiative and the various improvement activities/ideas that are being implemented, tested and spread. A "Continuous Improvement Board" using a LEAN approach was developed as tool for the HCC managers to use with their staff to provide education and engagement around IPCC related activities. PDSA cycles were described for each of the integration improvement initiatives.

- The following improvements are being implemented to achieve integration of care:
  - **Standard Referral Form and Long Term Care 1 (LTC1) Report** These improvements are in the spread phase. The new referral process has the following components:
    - Standard Referral Form which has description of services offered by Richmond Continuing Health Services, admission criteria, and patient information needed to accelerate referral process.
    - Feedback to referring Family Physician by phone or fax confirming that referral has been received and patient has been contacted.
    - Mailing out the LTC1 report post patient assessment which provides Family Physicians with a better understanding of how well the patient is managing at home and what supports are in place and name and contact information of the case manager.

  - **Screening-Tracking Tool for Frail Elderly** - This one-page screener was developed with Family Physicians to use in their practice to actively case find frail elderly patients who could benefit from referral to Case Management service. This tool has been tested and improved, and will be retested by Family Physicians.

  - **Medication Management** The use of the BC Patient Safety and Quality Council medication card is being tried by five GPs on 10 of their patients. Patients document their current medication on the card and are encouraged to share the card with every health care provider they see besides the GP such as Home Care Nurse, Chronic Disease Nurse, Pharmacist. The card is wallet size so it makes it easy to carry. The objective is to improve communication between the different health care providers and ultimately reduce medication errors. As of May 18th, 2012, 15 patients have created a complete and accurate medication list using the BC Patient Safety and Quality Council medication card of which 2 patients have returned to the family physician for a follow-up appointment with no changes to their medication list.

  - **Senior's Community Resource List and Key Community Agency Partnerships** The goal is to develop a list that provides information for long term *Live-in or Live-out* care services or companion support for older adults and/or families for use by primary care physicians, Nurse Practitioners and VCH Staff; and another list that provides information on community resources and social service supports for seniors living in Richmond who are well at risk. The lists are being developed by the Working Group and community agencies are being involved.

  - **One Care Coordinator** The plan includes formalizing the work flow and coordination of care from an acute care perspective and from a community care perspective and articulating the care model for the "one care coordinator" role. The Working Group is gathering information on current communication tools that are being used by the various health care services such GPs and VCH Home First program, HCC services, GTN, CDN, and Family Case Conferencing in Hospital and how this information can be shared.

- **Community partnership** projects supported in 2012/13 are the following:
  - Wellness Connections Program - a transitional therapeutic recreation bridging program that enables frail isolated seniors and people with multiple chronic conditions to identify and master the skills for community recreation participation and community inclusion.
  - First Link a first response strategy for people newly diagnosed with dementia and their families. It includes proactive outreach, information and connections, and planned follow-up.

4. Pemberton in Sea-to-Sky

- The Working Group identified the following opportunities for improvement:
  - Development of Pemberton Valley Community resource directory to pull together the resources from Mt. Currie, Southern Stl'atl'inx Health Society (SSHS) and VCH in a single location.
  - To hold a "Gathering Community" event to help shape the work of IPCC. The intent is to build relationships, increase awareness of each other's roles, share knowledge, and/or enhance cultural competency.

- VCH First Nations IPCC Advisory Consultants are helping to facilitate the engagement with First Nation Health leaders and community members around local visions and priorities for integrated primary and community care.

- **Community partnership** project supported in 2012/13 is the Bowling for Life an opportunity for seniors of Pemberton and elders in Mt. Currie to come together for an afternoon or wii bowling and lunch.

5. Downtown Eastside (DTES) Vancouver

- DTES IPCC Working Group reviewed the group profile of the 89 patients who visited St. Paul's Emergency Department 10+ times during the year and are known to VCH family physicians and Nurse Practitioners.

- Working Group agreed on an **integrated care process for the high ED users** that includes the following elements:
  - Creating a registry for tracking purposes
  - Reviewing the client file to better understand total care needs
  - Connecting with St. Paul's Emergency Department in care planning and care management
  - Meeting with clients to understand reasons for going to ED and get inputs in goal setting
  - Case conferencing among care involved
  - Care plan development
  - Care Plan Implementation
  - Tracking and Evaluation

- Senior Medical Director, who is the Data Steward of personal information on the 89 clients, met with the clinical teams in the five DTES primary care sites to share names and specific information of their clients who are high ED users, and initiate integrated care meetings to implement improved care processes.

- General process maps have been developed of the five primary care sites and St. Paul's ED Designated Medical Profile (DMP) Program as baseline information for process improvement. (The DMP Program identifies high ED users and develops an ED care plan for each.)

- **Primary Outreach Services Teams** continues to hold clinics in single occupancy hotels (SROs) and shelters providing mental health, addiction and primary care. They also provide ongoing case management and health care support to clients.

- **Community partnerships** continue to be supported in SROs to provide tenancy supports through the non-profit organizations including: Raincity Housing and Support Society and Portland Hotel Society Community Services.

Key Issues, Dependencies and Mitigation Strategies:

Issues/dependencies/barriers	Mitigation Strategy:
• Physician engagement and involvement in implementing improvements	Continuous engagement and support from Division of Family Practice
• VCH staff engagement and involvement in implementing improvements	Continuous engagement and support from managers and directors
• Better communication with other community providers to avoid duplication e.g. repeat assessments and tests	Establish integrated care process
• Turnover in the leadership of First Nations partners; and Lack of full understanding regarding the coming changes through the First Nations Health Authority	Continuous building of relationship and assistance from VCH First Nations IPCC Advisory Consultants
• VCH community leaders and managers face tremendous work pressures their time is limited and are faced with competing priorities	Priority setting and support from local leadership

Successes and Lessons Learned:

- Face-to-face, in person communication, one-to-one follow-up with persons involved in introducing improvements are highly effective and open up lines of communication and dispel myth.
- Ongoing communication and regular interaction of local team with regional IPCC team allow for more team cohesion and alignment of perspectives.
- Support from VCH community leaders/managers at every level of IPCC activity is key to helping drive the IPCC work and is crucial to success.
- Taking the time to get inputs from Family Physicians regarding tools and communications forms affecting their practice is key to implementing improvements.
- Need to be flexible regarding the usage of the Quality improvement/LEAN framework e.g. more uptake if issues are framed as opportunities.

QUARTERLY REPORT (Section 2) – April 1, 2012 to June 30, 2012

	Community Based Service Delivery Areas	Communities included in CBSDA	Total Population of CBSDA	Version #[1] /stage planning & implementation	Division *-In place -In Progress -Not started*	# Family Physicians engaged (re ated to vers on/ terat on)	CSC *-In place -In Progress -Not started*	Target Population(s) *Name (i.e. frail elderly – home health) & Case definition*	# People in the Target Population *(estimate based on case definition - denominator)*	# Patients receiving new or redesigned services *(cumulative # of unique patients)*	% Reach[2]
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2.	North Shore	North Vancouver & West Vancouver	186,776	Planning & testing improve ments	In place	2 in IPCC planning 14 with complex care navigator; 16 with case conferenci ng	In place	Very High & High morbidity	17,906	▪ Complex care navigator – 39 patients ▪ Case manager and GP care conferencing – 27 patients; ▪ Chronic Disease Nurse* in GP practices – 473 patients	
3.	Richmond	Richmond	189,027	Planning	In place	15 in planning & testing	In place	Frail elderly: age 80+ and 70-79 with Alzheimer/ dementia	7,178	▪ Screening-Tracking Tool – 20 patients; ▪ Medication Card – 15 patients; ▪ Chronic Disease	

[1] *Version # indicates progress using incremental improvements; if your HA uses a stages of implementation framework, please indicate that status/iteration)*

[2] *Reach = number of patients receiving services (cumulative count)/ number of patients in target population (actual as per case definition, or estimate)*

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 2) – April 1, 2012 to June 30, 2012

										Nurses* in GP practices - 621 patients	
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5.	Vancouver - Downtown Eastside (DTES)	Downtown Eastside Core	61,242	Planning	In place	2 in IPCC planning;	In place	Complex marginalized population	8,000 residents in DTES core; 89 High ED users of St. Paul's Hospital – visited 10+ during the year	700 patients continued to receive services from the primary care outreach team in 16 Single Room Occupancy hotels (started under IHN)	
6.	Vancouver - Except DTES	All LHAs except DTES	568,663		In place		In place			621 patients continued to receive service from Chronic Disease Nurses in GP practices*	
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* Chronic Disease Nurses in GP practices under the IHN model will be combined with IPCC in the care model that the community decides.

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 3)

	Community Based Service Delivery Areas **2011/2012**	Collaborative Services Committee priority issues/ <List-may coincide with CSC agendas or IHN Steering Committee Agenda> Below are VCH Local IPCC Steering Committee agenda/issues:	Describe planned new or redesigned services (and % implemented) < describe **key integration** activities that are being prototyped; **include numbers of other providers** such as case managers, nurse practitioners etc >	Patients as Partners Specific examples of how this service delivery element is being embedded by CBSDA i.e. Patient/community partner on CSC; training etc	Care Planning - Coordinated / Shared Care Plans (key elements or, operational definition ; # shared care plans per GPSC billing fee)
1.	Powell River	▪ Sharing of information between GPs and VCH home health & mental health teams ▪ Timely communication ▪ Shared care plan – eventually electronic ▪ Building community partnerships	▪ Mental Health Counsellor in a physician-led methadone clinic ▪ Home Care Nurse in a GP practice ▪ "At-risk" users/presenters to ED ▪ Connecting pregnancy (Interdisciplinary primary maternity care group visits)	▪ Patient representation in IPCC planning such as regional land local IPCC steering committees or working group ▪ Formal orientation of patient representatives before involvement in steering committees/working group ▪ Various ways of capturing patient voice such as patient survey, focus groups and patient journey mapping	Care planning is done as part of case conferencing between GP and community care providers e.g. case manager, home care nurse. Possible measures include: ▪ Patients in the target population who have a care plan based on GP billing ▪ Patients in the target population who have a care plan in VCH's PARIS (Primary Access Regional Information System) or other tracking system
2.	North Shore	▪ Proactive identification of high risk patients ▪ Linking GPs and VCH home health & mental health teams ▪ Building community partnerships	▪ Proactive case finding protocols ▪ Complex Care Navigator supporting GPs ▪ GP and Case Manager case conferencing ▪ Home and Community Care intake redesign ▪ Smart phone app on programs and services	Same as above	Same as above

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 3)

3.	Richmond	▪ Proactive frailty assessment of all people age 80+ ▪ Improving referral and service delivery processes between GPs and VCH home health teams ▪ Improved communication and interaction of among team of care providers	▪ Standard referral form for all home health services and LTC 1 assessment report to GPs ▪ Screening-Tracking Tool for the frail elderly ▪ Medication management ▪ Senior's Community Resource List and Key Community Agency Partnerships ▪ One care coordinator	Same as above	Same as above
4.	Howe Sound - Pemberton	▪ Building on integration practices in current system ▪ Integration between services at Pemberton Health Centre and Mount Currie and Southern Stl'atl'inx Health Centres	Discussion ongoing	Same as above	Same as above
5.	Vancouver - Downtown Eastside (DTES) Core	▪ Defining the target population ▪ Building on current initiatives to integrate services between VCH GP clinics and home health & mental health teams ▪ Targeting high ED users and improving primary and community care delivery	Integrated care process that has the following elements: ▪ Creating a registry for tracking purposes ▪ Reviewing the client file to better understand total care needs ▪ Connecting with St. Paul's Emergency Department in care planning and care management ▪ Meeting with clients to understand reasons for going to ED and get inputs in goal setting ▪ Case conferencing among care involved ▪ Care plan development ▪ Care plan implementation ▪ Tracking and evaluation	Same as above	Same as above

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

INTEGRATED PRIMARY AND COMMUNITY CARE

QUARTERLY REPORT (Section 1)

Health Authority : Vancouver Coastal Health	Reporting Period: July 1 to September 30, 2012
Completed by: Venie Dettmers	Submitted to MOH: September 25, 2012

Summary of Major Progress and Key Accomplishments Since Last Report

Macro (across HA):

- **Accelerated Integrated Primary and Community Care**
  The implementation of the following projects has started with Accelerated IPCC funding:
  - ***Home is Best*** Provides an enhanced home based service to clients who would otherwise be moved to residential care. Care is provided by an interdisciplinary team with the following focus: intensive care management; and an enhanced mix of community-based services designed to meet the needs of clients with multiple, complex and interacting chronic diseases and/or social and environmental factors.

  - ***Acute Home Based Treatment (AHBT)*** Provides home-based treatment for mental health and addictions clients as an alternative to hospitalization. The AHBT team consists of psychiatrists, clients, families, GPs and nursing staff supported by social workers, counsellors, or rehabilitation professionals as required. This team follows clients and provides intensive short-term treatment in the clients' home.

  - ***Early Supported Discharge*** In collaborative partnership with GPs, an interdisciplinary community reintegration team supports patients through an early discharge from acute care. The team will provide short term rehabilitation for up to three months that includes: coordination, education, and provision of self-care management education and support to patients and caregivers to enable them to have knowledge and skills needed to manage their chronic condition.

  - ***Assertive Community Treatment (ACT)*** A client-centered, recovery-oriented mental health service delivery model, the ACT team is mobile and delivers services in community locations to enable clients to continue to live in their community. This service is provided 24 hours a day by a multidisciplinary team, including a GP, with a low client to provider ratio.

  - ***Care Management*** Aims to redesign VCH Home Health services to align with the provincial care management strategy and integrate teams with primary care in each community. The components are: delivery of the provincial care management curriculum, inter-professional care conferencing between GP and home health team members, and telephonic care management.

  - ***First Nations IPCC Advisory Team*** The Team will facilitate engagement with First Nations and community members to develop local visions and priorities for IPCC. Awareness and education work in communities with respect to primary care will assist in identifying local models for primary care service provision.

- **Care Management Strategy**
  The Care Management Strategy is being implemented through these projects: Redesign of Home and Community Care Services in Powell River, and rollout of GP care conferencing in the North Shore and Vancouver supported by the accelerated IPCC Care Management project. See details in

community section of this report.

- **Patients as Partners**
  Patients were recruited and involved in the following ways: patient representatives in the Richmond IPCC Steering Committee, patient interviews to capture patient perspective in the DTES IPCC project, participation in a focus group related to the Powell River Connecting Pregnancy Project, and participation in current state mapping of the Care Management initiative in Powell River. Implementation of community partnerships was also supported. See details in community section of this report.

- **Evaluation**
  Developed/implemented evaluation plans for improvement initiatives. As well, several provider baseline surveys have occurred, provider reflective sessions, Communities of Care reflective sessions (Powell River and Richmond), patient interviews (DTES) and patient focus groups (Powell River Connecting Pregnancy). Please see details in community reports. The Lead Evaluator has also been very active since June with the Accelerated IPCC projects in helping design the evaluation plans for these projects. In the past week, a Community Evaluator (through funds from the MSRF) was hired who will assist the Lead Evaluator in the large body of IPCC work.

Meso and Micro (for specific populations or patient groups; by CBSDA):

1. Powell River

- The Powell River IPCC Steering Committee:
  - Adjusted its working model by having as co-chairs the manager of Home and Community Care and a primary care physician who also represents Division of Family Practice. Co-chairing started at the September meeting.
  - Submitted a Nurse Practitioner proposal involving First Nations, Community Physicians and VCH staff.

- The following improvements are being implemented to achieve integration of care:
  - **VCH Mental Health (MH) and Addictions Counselor in a Physician-led Methadone Clinic** - The objective is to develop a more integrated team approach that involves patients, family physician and VCH mental health counsellor. The MH counsellor meets clients within the Methadone clinic one morning each month. Eleven patients have been provided care under this approach.

  - **VCH Home Care Nurse and Primary Care Physician Partnership -** A Home Care Registered Nurse is physically present in a primary care GP office every 2nd Wednesday for 2+ hours. The partnership allows for live information sharing, a team approach when seeing patients, shared care planning, and more thorough understanding of each other's roles. Eleven patients have been involved or discussed within this shared care approach.

  - **Home Health Service Redesign** To better meet the need of clients, changes in practice of Home and Community staff are being implemented as part of the Care Management Strategy. Data collection including current services, delivery, staff resources and clients is almost complete. Workshops with will be held with the first one on September 26th with staff, GPs and patients attending to discuss the current state.

- **Intake Liaison Redesign Initiative** The objective is to develop a more streamlined and efficient referral process from GP to Home and Community Care (HCC) and communication process from HCC to GP. Being trialed in referring a patient to HCC is a new referral method similar to how GPs share information to specialists. Also being trialed is a new standard reply form from HCC to GP confirming referral received, Expected Time of Arrival date of service, and contact information for most responsible VCH personnel.

- **Connecting Pregnancy Program** - The objective is to develop a rural model of interdisciplinary primary maternity care. The program is co-facilitated by a family physician (who provides individual prenatal care during the sessions) and a public health nurse. Guest speakers provide added information. A group of six to eight women and their partners attend 9 group sessions over 18 weeks (every other week). Three cohorts have participated thus far. Evaluation is ongoing consisting of focus group and reflective interviews with patients; report will be completed in November.

- **"At Risk" Users/Presenters to the ED** The objective is to better respond to "at-risk" or "high use" patients whose care can be improved by better coordination through the Powell River Hospital Emergency Department. Based on Pareto Analysis, the focus will be on people presenting with Chronic Pain, Mental Health and/or an Addiction Crisis, Chronic Conditions with acute exacerbations, Falls, Urinary Tract Infections, and Post-Chemotherapy pain, nausea, frailty. An integrated care process consisting of four sub-improvement initiatives will be piloted over an 18 month period to improve proactive delivery and quality of care, and coordination among care providers.

- **Community partnership** projects funded in 2012/13 to support people with chronic conditions or mental health/substance use problems are the following:
  - ***Building Recovery of Individual Dreams & Goals through Education (BRIDGES)*** provided by the BC Schizophrenia Society a course taught by consumers for consumers to empower people with tools that will help them in their journey to recovery. Train the trainer has happened during the first quarter and programs will be delivered in the fall.
  - ***Humble and Hearty Workshops*** provided by Powell River Employment Program Society offers a series of 18 workshops focusing on the preparation of low cost nutritious meals designed to include ingredients realistically accessible to low income people, specifically what is available from local free food resources. Number of workshops held: 7 with 66 referrals received. Feedback from participants showed extremely high positive ratings of the workshop.
  - ***Monday Brunch*** provided by Powell River Employment Program Society - provides access to meals with fresh fruits and vegetables for people with chronic health problems, and facilitates access to public health professionals and other educational and social supports. Number of brunches offered this quarter: 6 with an average of 31 participants.
  - ***Promoting Community Wellness*** provided by The Source Club Society - provides people living with mental illness with social and recreational activities, and opportunities to engag in healthy practices. Number of workshops conducted: 24 with 28 referrals

2. North Shore

- The North Shore IPCC Committee:
  - Revisited problem statement and revising the IPCC Project Charter.
  - Redesigned agenda to ensure voices of all representatives are heard e.g. mental health; and expanded membership to include First Nations representatives from Squamish and Tsleil-Waututh.
  - Updated Road Map of North Shore Integration Initiatives to reflect all integration-related initiatives.
  - Developing a plan to engage GPs in accelerated IPCC initiatives.
  - Redesigning brochure to communicate with local staff and the public.
  - Developing an overarching evaluation plan for all North Shore initiatives.

- The following improvements are being implemented to achieve integration of care:
  - **Complex Care Navigator Program** - The Complex Care Navigator/Chronic Disease Nurse Coordinator based in the Community Health Centre continues to support patients who are referred by their Family Physician for help in managing their chronic conditions. Since the beginning of winter 2011/2012, referrals have grown to 70 clients and 15 GPs. VCH staff are being explored as referral sources as awareness of the program has increased. The project is being evaluated.

  - **GP Care Conferencing** Care conferencing in person or over the phone between Home and Community Care (HCC) staff is being rolled out at the end of September/early October. Meetings with all disciplines and administrative support staff to outline the process are occurring throughout September. Positive response from staff was received. This builds on the testing of care conferencing with case managers in late winter/spring 2012 where 16 GPs and 27 clients were involved.

  - **Home and Community Care Intake Redesign** In response to a Lean analysis recommendation, an intake clerk position was created to reduce the amount of non-clinical administrative work such as faxing, collecting demographic information by intake nurses, and having 'live' clerical support answering calls. Intake clerk is orienting to new position.

  - **Smart Phone App** The objective is to make information about programs and services that support the health and wellness of the North Shore population accessible to physicians and their MOAs. Stage 1 which involved the design of the App and data entry is complete and preliminary testing showed positive results in terms of ease of access and searching. Stage 2 will involve the testing of the App, the development of a complementary website for those without access to a smart phone. Three GPs are involved as members of the Working Group.

  - **Community partnership** projects funded in 2012/13 to support people with chronic conditions or mental health/substance use problems are the following:
    - ***Counseling Service*** - individual and group counseling for individuals experiencing mild to moderate depression and chronic illness. Patients seen during the quarter: 16.
    - ***Seniors Peer Support Volunteer Program*** - offers one-on-one emotional support, guidance regarding life changes and challenges, as well as provide resource information. Referrals received during the quarter: 30 who were provided 120 support hours.
    - ***North Shore Keep Well*** - an exercise and wellness program for mobile seniors to

encourage and help older adults to keep well by leading active and independent lives. The program includes one hour of exercise followed by blood pressure checks and health coaching, massage, speakers and social times. Total attendees during the quarter in 7 sites: 3,177.

- ***First Link*** a first response strategy for people newly diagnosed with dementia and their families. It includes proactive outreach, information and connections, and planned follow-up. Project is in start-up phase.

- North Shore Shared Care Initiatives:
  - With funding from the Shared Care Committee, the North Shore Division has begun partnering with their specialist colleagues to improve processes related to the sharing of care e.g. communication, access to care, work flow, referral, etc.. The areas of focus are: Oncology, Orthopaedics, Psychiatry and Pediatrics. Improvements are in the planning stage.

3. Richmond

- The Richmond IPCC Committee:
  - Reviewed the seven Accelerated IPCC initiatives which highlighted the focus to ensure GP engagement and linkages with existing IPCC activities, patients as partners and other related provincial initiatives.
  - Reviewed the draft Nurse Practitioner proposal; GPs offered to provide feedback prior to submission.
  - Expanded membership to include two patient representatives who attended August meeting.
  - Completed Project Charter on expanding the role of the Chronic Disease Nurse to provide support to GPs and their patients who do not have a CDN on site. Intervention would include assessment, care planning, screening, education coordination of services and self management support. Initial plan is to involve GPs on the IPCC Committee.
  - Continued to provide support to HCC leaders re design of an effective communication strategy and creation of communication tools to keep their staff engaged and informed around IPCC activities. An evaluation baseline survey was carried out to staff to get a better understanding of their awareness re IPCC. These results were shared with the senior leaders and managers. The survey will be repeated in the new year.

- The following improvements are being implemented to achieve integration of care:
  - **Standard Referral Form and Long Term Care 1 (LTC1) Report** The objective is to streamline the referral process from GP to HCC and feedback to GPs. The improvements are in the spread phase. An evaluation plan has been created and data collection is ongoing. Next step is to review the data in November 2012.

  - **Screening-Tracking Tool for Frail Elderly** This one-page screener was developed with Family Physicians to use in their practice to actively case find frail elderly patients who could benefit from referral to Case Management (CM) service and to proactively identify clients who are not eligible for CM, but are at risk and may benefit from social supports and services available in the community. This redesigned tool is currently being tested with IPCC GPs and Chronic Disease Nurses until end of September. An evaluation survey will be implemented for feedback.

  - **Medication Management** The objective is to improve communication between the

different health care providers and ultimately reduce medication errors. The testing of the use of the BC Patient Safety and Quality Council medication card is being expanded to 20 GPs. Patients document their current medication on the card and are encouraged to share the card with every health care provider they see besides the GP such as Home Care Nurse, Chronic Disease Nurse, Pharmacist.

- **Senior's Community Resource List and Key Community Agency Partnerships** The objective is to have one list/package that has information on community supports and resources that will be housed in a common place and be updated regularly. Providers will have access to the resource list and refer patients to resources and programs in the community. One patient and two GPs are involved in this effort. Two lists have been created in a way that have value to the GPs.

- **One Care Coordinator** The objective is to formalize the work flow and coordination of care from an acute care perspective and from a community care perspective and articulating the care model for the "one care coordinator" role. The sub working Group continues to gather information on current communication tools that are being used by the various health care services, in particular with the Home First program. The focus is on ensuring that the tools and processes developed are consistently being followed. A communication document describing the Home First program has been created for GPs. In addition, the focus is also on how best to engage the participation of GPs in Family Conferences in Acute Care.

- **Community partnership** projects supported in 2012/13 are the following:
  - ***Wellness Connections Program*** - a transitional therapeutic recreation bridging program that enables frail isolated seniors and people with multiple chronic conditions to identify and master the skills for community recreation participation and community inclusion.
  - ***First Link*** a first response strategy for people newly diagnosed with dementia and their families. It includes proactive outreach, information and connections, and planned follow-up. The project is in the start-up phase.

4. Pemberton in Sea-to-Sky

- The Pemberton Committee:
  - Expanded its membership to include the Consultant with VCH Aboriginal Health Strategic Initiatives and IPCC whose key role is to work closely with the First Nations communities and provide information and support related to IPCC activities.
  - Added also to the Committee is the new Health Director for Southern Stl'atl'inx Health Society (SSHS).
  - Reviewed draft Nurse Practitioner proposal involving First Nations, Community Physicians and VCH staff.

- The Committee continued to provide support and direction to the identified opportunities for improvement:
  - Development of Pemberton Valley Community **resource directory**.
  - ***Coming Together*** **event** to be held on October 18th at Mount Currie. This is a joint effort between Mt. Currie and SSHS health leaders, community physicians and VCH staff and managers. The purpose is to gain awareness of the services and programs offered within First Nations communities, Primary Care and VCH as well as to meet the individuals who provide

the services.

- **Community partnership** project supported in 2012/13 is the ***Bowling for Life*** an opportunity for seniors of Pemberton and elders in Mt. Currie to come together for an afternoon of Wii bowling and lunch. Number of participants: 66

5. Downtown Eastside (DTES) Vancouver

- The pilot implementation of the **integrated care process for the high ED users** is underway. High ED use clients are those who visited St. Paul's Hospital ED 10 or more times between April 1, 2011 to February 2012. The integrated care process includes the following elements: registry, review of client file, identifying primary care lead, reviewing ED care plan, identifying other clinicians, meeting with client, case conferencing with client, developing a care plan, sharing the care plan and care plan follow-up.
    - The five VCH primary care sites (Downtown, Pender, Strathcona, Primary Outreach and Vancouver Native Health) have their registry of high ED use clients. A Team Lead has been identified in each site to initiate and support the pilot implementation of the integrated care process. To date, chart review has been done on 56 of the 89 identified high use clients, and the primary care lead has been identified for 24 clients.

    - Evaluation plan has been finalized; provider and patient experience surveys are ongoing to gather baseline information.

- **Primary Outreach Services Teams** continues to hold clinics in single occupancy hotels (SROs) and shelters providing mental health, addiction and primary care. They also provide ongoing case management and health care support to 700 clients.

- **Community partnerships** continue to be supported in SROs to provide tenancy supports through the non-profit organizations including: Raincity Housing and Support Society, and Portland Hotel Society Community Services.

6. Vancouver

Vancouver Community of Care has initiated projects that facilitate integration of care. They include:

- **Ideal Transition Home** The goal is to improve the patient and family experience and provide quality outcomes for patients discharged from VGH. The interventions are:

  Within 48 hours of admission:
    - *Readmission Risk assessment* score initiated (early identification of patients at moderate to high risk for readmission)
    - *Readmission Risk mitigation checklist* initiated (standardized interventions)
    - *Hospitalization notice* faxed to GP in community
    - *Referral* sent to community for known clients and for assessment for new clients

  And upon discharge:
    - *My Discharge Plan is* completed and given to patient/family and faxed to community and community GP (discharge notification fax).
    - *High risk patients* - Follow up GP appointment made prior to discharge for 48 hours post discharge.
    - *Moderate risk patients* Follow up GP appointment made prior to discharge for 3-5 days post discharge and a follow up phone call to patient/family by Care Management Leader

48 hrs post discharge.

Since May 14, a total of 1,229 patients have been screened. From July 12- August 16, 2012, 330 patients were screened, 43% identified as moderate risk, 34% identified as high risk. As of August 21, % of time transition plan transferred with patient (mod/high risk) was 90%; % of patients with scheduled follow up appointments before discharge (mod/high risk) was 70%. Readmission rate was 9.6%.

- **GP care conferencing** This involves care conferencing between GP and VCH home health staff and is in the planning stage.

Key Issues, Dependencies and Mitigation Strategies:

Issues/dependencies/barriers	Mitigation Strategy:
• **Powell River**	
○ With the Case Management Strategy still being piloted, the HCC RN does not have the tools/training of a case manager to meet expectations of the GP.	• Clarify roles and expectations.
○ Methadone clinic issues: High number of no shows; GP needs more time from the counsellor; and charting of clients at both the methadone clinic and the VCH mental health team info system.	• Evaluate and make appropriate decision.
○ Sustaining effort to implement changes in practice.	• On-going communication and reminders.
• **North Shore**	
○ More GPs need to be engaged in Complex Care Navigator Program; and also middle-aged still independent clients who can benefit from self-management support.	• Change GP impression that this is one-off consultation service, but an ongoing partnership to provide CDM; address barriers of middle-aged clients such as time for appointments.
○ Changing engrained work habits in implementing care conferencing and intake redesign.	• Continuous staff engagement.
○ Distinguishing the Smart Phone App from resources such as CHARD and Red/Green book.	• Prepared document listing pros and cons of the 3 approaches to access service information.
• **Richmond**	
○ Seniors community resource list also produced by Volunteer Richmond.	• Review this initiative and explore if Volunteer Richmond can take on this initiative.
○ Time needed by GPs to use the screener tool for frail elderly.	• Build on positive experience of GPs who have used the tool in motivating other GPs.
• **Pemberton**	
○ Turnover of health leadership in First Nations	• Flexibility in process and timeline

communities • **Downtown Eastside** ○ Time for providers to undertake improvement work. ○ Coordinating with teams and getting people together. ○ Finding these patients who are inherently challenging.	• Leads/managers to address time management issue. • Monthly teleconference for team leads to share successes and challenges. • Mobilize outreach resources to find clients.
Successes and Lessons Learned:	
• It takes time to build relationships for ongoing collaboration. • Collaboration among all team members is key to success. • Continuous engagement of care providers is needed to integrate care for complex clients. • Building on positive experience of GPs/providers in motivating others. • Local leadership and ownership of the project facilitate implementation. • Clear vision of integration/integrated care generates buy-in. • Project documents e.g. TOR should be considered as living documents.	

QUARTERLY REPORT (Section 2) – July 1, 2012 to September 30, 2012

	Community Based Service Delivery Areas	Communities included in CBSDA	Total Population of CBSDA	Version #[1] /stage planning & implementation	Division *-In place -In Progress -Not started*	# Family Physicians engaged (re ated to vers on/ terat on)	CSC *-In place -In Progress -Not started*	Target Population(s) *Name (i.e. frail elderly – home health) & Case definition*	# People in the Target Population *(estimate based on case definition - denominator)*	# Patients receiving new or redesigned services *(cumulative # of unique patients)*	% Reach[2]
1.	Powell River	Powell River	19,733	Testing improve ments	In place	2 in Steering Committee & 10 in various testing/ PDSAs	In place	Very High & High morbidity with cardio-vascular disease or Mental Health & Substance Use problems	1,722	▪ Home care nurse and GP shared care - 11; ▪ Mental health counsellor in GP practice - 11 ▪ Connecting Pregnancy - 24 ▪ Community partnership projects - 274	
2.	North Shore	North Vancouver & West Vancouver	186,776	Testing improve ments	In place	2 in Steering Committee; 15 referring to Complex Care Navigator; 19 in various testing/ PDSA	In place	Very High & High morbidity	17,906	▪ Complex care navigator – 70 ▪ Case manager and GP care conferencing – 27 patients; ▪ Chronic Disease Nurse* in GP practices – 473 patients ▪ Community partnership projects – 3,223	
3.	Richmond	Richmond	189,027	Testing improve ments & Spread	In place	15 in Steering Committee who are	In place	Frail elderly: age 80+ and 70-79 with Alzheimer/ dementia	7,178	▪ Screening-Tracking Tool – 20 patients; ▪ Medication Card – 15 patients;	

[1] *Version # indicates progress using incremental improvements; if your HA uses a stages of implementation framework, please indicate that status/iteration)*

[2] *Reach = number of patients receiving services (cumulative count)/ number of patients in target population (actual as per case definition, or estimate)*

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 2) – July 1, 2012 to September 30, 2012

						also involved in PDSAs/ testing				▪ Chronic Disease Nurses* in GP practices - 621 patients	
4.	Howe Sound	Pemberton Squamish Whistler	33,458; Pemberton on y=5,118	Planning	In prog-ress	2 in Pemberton IPCC Committee		Population in Mt. Currie Reserve and Southern Stl'atl'inx	1,800	Chronic Disease Nurse in GP practices – 51 from First Nations communities	
5.	Vancouver - Downtown Eastside (DTES)	Downtown Eastside Core	61,242	Testing improve ments	In place	8 in IPCC Steering Committee and Working Group; 24 involved in the care of 89 patients	In place	Complex marginalized population	8,000 residents in DTES core; 89 High ED users of St. Paul's Hospital – visited 10+ during the year	• Integrated care process - 56 patients • 700 patients continued to receive services from the primary care outreach team in 16 Single Room Occupancy hotels (started under IHN)	
6.	Vancouver - Except DTES	All LHAs except DTES	568,663	Spread	In place	254 GPs of moderate to high risk patients	In place		Moderate to high risk patients	• 621 patients continued to receive service from Chronic Disease Nurses in GP practices* • 330 patients screened in Ideal Transition Home program, of which 77% are mod/high risk	
7.	Sunshine Coast	Sunshine Coast	28,936		In place						
8.	Bella Coola Valley and Central Coast	Bella Coola Valley & Central Coast	4,290								

* Chronic Disease Nurses in GP practices under the IHN model will be combined with IPCC in the care model that the community decides.

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 3)

	Community Based Service Delivery Areas **2011/2012**	Collaborative Services Committee priority issues/ <List-may coincide with CSC agendas or IHN Steering Committee Agenda> Below are VCH Local IPCC Steering Committee agenda/issues:	Describe planned new or redesigned services (and % implemented) < describe **key integration** activities that are being prototyped; **include numbers of other providers** such as case managers, nurse practitioners etc >	Patients as Partners Specific examples of how this service delivery element is being embedded by CBSDA i.e. Patient/community partner on CSC; training etc	Care Planning - Coordinated / Shared Care Plans (key elements or, operational definition ; # shared care plans per GPSC billing fee)
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2.	North Shore	▪ Proactive identification of high risk patients ▪ Linking GPs and VCH home health & mental health teams ▪ Building community partnerships	▪ Complex Care Navigator supporting GPs ▪ GP care conferencing ▪ Home and Community Care intake redesign ▪ Smart phone app on programs and services ▪ Community partnerships ▪ GP-specialist shared care in oncology, orthopaedics, psychiatry and pediatrics.	Same as above	Same as above
3.	Richmond	▪ Proactive frailty assessment of all people age 80+ ▪ Improved communication and interaction of among	▪ Standard referral form for all home health services and LTC 1 assessment report to GPs ▪ Screening-Tracking Tool for the frail elderly ▪ Medication management ▪ Senior's Community Resource List and Key	Same as above	Same as above

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 3)

		team of care providers	Community Agency Partnerships ▪ One care coordinator		
4.	Howe Sound - Pemberton	▪ Building on integration practices in current system ▪ Integration between services at Pemberton Health Centre and Mount Currie and Southern Stl'atl'inx Health Centres	▪ Pemberton Valley community resource directory ▪ Coming Together event ▪ Community partnership	Same as above	Same as above
5.	Vancouver - Downtown Eastside (DTES) Core	▪ Targeting high ED users to reduce their Ed visits ▪ Integration of care processes ▪ Efficient proactive community-based care	Integrated care process that has the following elements: ▪ Creating a registry ▪ Reviewing the client file ▪ Identifying the primary care provider ▪ Reviewing care plan in St. Paul's Emergency Department ▪ Meeting with client to understand reasons for going to ED and get inputs in goal setting ▪ Case conferencing including the client ▪ Developing a comprehensive care plan ▪ Sharing the care plan ▪ Following-up on care plan	Various ways of capturing patient voice such as patient survey, focus groups	Same as above
6.	Vancouver – Except DTES	▪ Transitions and care coordination to primary and community care providers for patients discharged from acute care	Ideal Transition Home initiative aims to: • Improve core discharge planning and transition processes from acute care • Improve transitions and care coordination to primary and community care providers • Enhance patient coaching, education, and support for self-management • Reduce readmission rates – a key quality of care indicator	Various ways of capturing patient voice such as patient survey, focus groups	% of time transition plan transferred with patient (Mod/high risk)

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

INTEGRATED PRIMARY AND COMMUNITY CARE

QUARTERLY REPORT (Section 1)

Health Authority : Vancouver Coastal Health	Reporting Period: October 1 to December 31, 2012
Completed by: Venie Dettmers	Submitted to MOH: December 21, 2012

Summary of Major Progress and Key Accomplishments Since Last Report

Macro (across HA):

- **Regional IPCC Team Reorganization –** The regional IPCC change team is being reorganized to have a Community Lead for each IPCC community. The scope of work of the Community Lead includes community-based integration initiatives as well as regional and provincial initiatives. The Community Lead will facilitate the linkages and coordination between integration initiatives.

- **IPCC Evaluation:** Two additional evaluators have been added to the Regional IPCC Team: "Community Evaluators." The evaluation of each project is described in the next section along with status of the project.

- **Accelerated Integrated Primary and Community Care Initiative**
  In addition to integration projects under the IPCC bilateral agreement, the projects listed below are being implemented with Accelerated IPCC funding starting this fiscal year. Separate reports are submitted to the Ministry.

  - ***Home is Best*** Provides an enhanced home based service to clients who would otherwise be moved to residential care. Care is provided by an interdisciplinary team with the following focus: intensive care management and an enhanced mix of community-based services designed to meet the needs of clients with multiple, complex and interacting chronic diseases and/or social and environmental factors.

  - ***Early Supported Discharge*** In collaborative partnership with GPs, an interdisciplinary community reintegration team supports patients with COPD, CHF and stroke through an early discharge from acute care. The team provides short term rehabilitation for up to three months that includes: coordination, education, and provision of self-care management education and support to patients and caregivers to enable them to have knowledge and skills needed to manage their chronic condition.

  - ***Frail Seniors Transition*** Expands interdisciplinary teams that address the community transition needs of older adults (70 + years) who present to ED to support prevention of unnecessary acute care admissions, provide seamless transitions to community and primary care resources after an emergency visit, and provide a coordinated approach to manage complex geriatric issues. The teams include geriatric triage/emergency nurses, transitions nurses for follow up support in the community and community-based pharmacists.

  - ***Care Management*** Aims to redesign VCH Home Health services to align with the provincial care management strategy and integrate teams with primary care in each community. The components are inter-professional care conferencing between GP and home health team members and telephonic care management.

- ***Acute Home Based Treatment (AHBT)*** Provides home-based treatment for mental health and

addictions clients as an alternative to hospitalization. The AHBT team consists of psychiatrists, clients, families, GPs and nursing staff supported by social workers, counsellors, or rehabilitation professionals as required. This team follows clients and provides intensive short-term treatment for up to 21 days in the clients' home.

- ***Assertive Community Treatment (ACT)*** A client-centered, recovery-oriented mental health service delivery model, the ACT team is mobile and delivers services in community locations to enable clients to continue to live in their community. This service is provided 24 hours a day by a multidisciplinary team, including a GP, with a low client to provider ratio.

- ***First Nations IPCC Advisory Team*** The Team facilitates engagement with First Nations and community members to develop local visions and priorities for IPCC. Awareness and education work in communities with respect to primary care will assist in identifying local models for primary care service provision.

Meso and Micro (for specific populations or patient groups; by CBSDA):

1. Powell River

- Powell River IPCC Steering Committee
  The Committee is implementing a new working model by having as co-chairs a family physician, mental health and addictions services manager, and home and community care manager. The Terms of Reference have been adopted with the Committee providing direction and leadership in the development of an integrated primary and community care services to meet the needs of the Powell River community.

- The following improvement projects are being implemented to achieve integration of care:

  1. **Methadone Clinic and Mental Health Counsellor Integration Initiative** - The objective is to develop a more integrated team approach that involves patients, family physician and VCH mental health counsellor. The MH counsellor meets clients within the Methadone clinic one morning each month. Thirteen patients have been provided care under this approach. ***Stage of Project****:* Pilot put on hold, being recommended to Steering Committee to discontinue pilot and to investigate other health authority-physician methadone programme partnerships.

  2. **Home Care Nursing and GP Partnership -** A Home Care Registered Nurse is physically present in a primary care GP office every 2nd Wednesday for 2+ hours. The partnership allows for live information sharing, a team approach when seeing patients, shared care planning, and more thorough understanding of each other's roles. The patient is directly present and involved in own care which a paradigm shift. Twenty patients have been cared for within this shared care approach. ***Stage of Project****:* Pilot put on hold. Further evaluation is required from GP, nurse and patient perspectives.

3. **Intake Liaison Redesign Integration Initiative** The objective is to develop a more streamlined and efficient referral process from primary care to Home and Community Care (HCC). ***Stage of Project:*** Pilot. Being trialed is a method that is similar to the e-referral process that primary care physicians use when referring a patient to a specialist from their EMR. An electronic version of the standard re*ferral form has b*een drafted. A protocol that involves providing communication back to the GP for each referral received is also being established.

4. **Home Health Service Redesign** To better meet the need of clients, changes in practice of Home and Community staff are being implemented as part of the Care Management Strategy. ***Stage of Project***: Planning. Three working groups have been established involving staff, union reps, GPs , patient reps and VCH leadership team. Completed to date is the current state map with identified issues/ gaps and opportunities such as GPs not fully aware of the services provided by home health, communication issues among team members and with GPs, and client/care giver being part of the care planning and decision making. Also completed are the ideal patient journey map, and discussion has started regarding target population groups. Data on staffing resources are being reviewed.

5. **Connecting Pregnancy Program** - The objective is to develop a rural model of interdisciplinary primary maternity care. The program is co-facilitated by a family physician who provides individual prenatal care during the sessions and a public health nurse. Guest speakers provide added information. A group of six to eight women and their partners attend 9 group sessions over 18 weeks (every other week). Three cohorts have participated thus far. ***Stage of Project:*** Pilot completed and evaluated; evaluation report being completed.

6. **"At Risk" Users/Presenters to the ED** The objective is to better respond to "at-risk" or “high use” patients whose care can be improved by better coordination through the Powell River Hospital Emergency Department. The overall arching goal is providing more coordinated and stronger first-time quality health care services. Based on Pareto Analysis, the focus is on the following:
    - **Chronic Disease (Acute Exacerbation):** A direct referral service for patients presenting to the ED with an exacerbation of one of three chronic diseases {CHF, CKD or COPD} to CDM RN services at 5 GP clinics is in progress. ***Stage of Project*:** Pilot/Testing. Pilot of current PDSA will conclude Dec 31st. Further assessment and other options are being discussed/ investigated such as amending CDM as a discharge supportive tool post-hospitalization admission.

    - **Mental Health or Addictions Crisis:** A new algorithm of standard practice is being applied in the ED for patients presenting with Mental Health or Addictions concerns that includes a Psychiatry Nurse coming to the ED and assess each patient upon notification from ED. ***Stage of Project:*** Large Scale Spread. All patients with mental health or addictions crises are now receiving the redesigned care approximately 1 patient per day. The large scale spread is currently being evaluated.

    - **Chronic Pain:** Current practices of treating patients with chronic as well as acute chronic pain episodes in the ED are being reviewed. ***Stage of Project:*** Planning Phase. A physician has been engaged into discussion as a referral pilot to treat patients with chronic pain. Further investigation regarding TeleHealth options connecting with regional chronic

pain supportive options are being followed up.

- **Acute Pain:** A change in practice for providing more appropriate first-time pain control

to patients presenting with acute pain is being assessed/reviewed. ***Stage of Project*:** Planning. Discussions regarding RNIA (Registered Nurse Initiated Action) are ongoing as one of the possible pilots. Powell River is potentially a pilot site for RNIA narcotic administration to improve pain control for patients in ED.

- **Falls Prevention:** Collection of demographic information on clients presenting with falls to the ED has begun. ***Stage of Project*:** Planning Phase. A re-visit of SAIL (community health falls initiative) and how this may be adapted to Acute is currently being done.

7. **Community partnership** projects funded in 2012/13 to support people with chronic conditions or mental health/substance use problems are the following:

   - ***Building Recovery of Individual Dreams & Goals through Education (BRIDGES)*** provided by the BC Schizophrenia Society a course taught by consumers for consumers to empower people with tools that will help them in their journey to recovery. Beginning November 19th, Support Group meetings for people who have been diagnosed with serious mental illness will be facilitated by peers who are coping well with their own mental illness and have been certified to deliver the BRIDGES program.
   - ***Humble and Hearty Workshops*** provided by Powell River Employment Program Society offers a series of 18 workshops focusing on the preparation of low cost nutritious meals designed to include ingredients realistically accessible to low income people, specifically what is available from local free food resources. Number of workshops held during the reporting period: 6 with 48 referrals received. Participants said that they used the recipes and greatly enjoyed the food, atmosphere, and knowledgeable instructor.

   - ***Monday Brunch*** provided by Powell River Employment Program Society - provides access to meals with fresh fruits and vegetables for people with chronic health problems, and facilitates access to public health professionals and other educational and social supports. Number of brunches offered during the reporting period: 10 with an average of 53 participants.

   - ***Promoting Community Wellness*** provided by The Source Club Society - provides people living with mental illness with social and recreational activities, and opportunities to engage in healthy practices. Number of workshops conducted: 24 with 28 referrals.

2. North Shore

- The following improvements are being implemented to achieve integration of care:

1. **GP Care Conferencing** Care conferencing in person or over the phone between Home and Community Care (HCC) staff was rolled out beginning of October. This rollout builds on the pilot testing of care conferencing with case managers in late winter/spring 2012. ***Stage of Project***: Pilot testing across all HCC clinicians. Workflow has been established and clerical support implemented to arrange conferences for clinicians. Fifty clients have had care conferences

conducted on their case. In total, 30 GPs have engaged in care conferencing with HCC staff.

2. **Home and Community Care Intake Redesign** In response to a Lean analysis recommendation, an intake clerk position was created to reduce the amount of non-clinical administrative work such as faxing, collecting demographic information by intake nurses, and having 'live' clerical support answering calls. ***Stage of Project:*** Pilot testing. As of December 2012, a new workflow is in the process of being implemented in order to reduce the bottleneck of referrals. In addition, regular feedback to GPs from HCC intake regarding the receipt of their referrals has been implemented in the form of faxing back the confirmation.

3. **Chronic Disease Nurse Coordinator Program** The objective is to engage family physicians to refer their patients with two or more chronic conditions for comprehensive guideline-based care to the Chronic Disease Nurse Coordinator who will support and help manage their chronic conditions. A key change idea for this program is that the CDN Coordinator is housed in a central location at a Community Health Centre rather than embedded in a Family Physician's private practice. The number of referrals is growing 61 received as of December 14th and a total of 20 GPs have referred to the program. ***Stage of Project:*** Evaluation of Pilot. In January, provider and patient experience will be evaluated.

4. **Smart Phone App** The objective is to make information about programs and services that support the health and wellness of the North Shore population accessible to physicians and their MOAs. A directory of physicians indicating their specialty will also be incorporated into the App and its web-based version. ***Stage of Project:*** Pilot/Testing. Continued pilot testing of the App and development of a complementary website for those without access to a smart phone. The working group recently held a contest for naming and designing the App/website logo. Recent software upgrades have been undertaken to provide better mobile connectivity features. Refinement of data fields for improved functionality and ease of keeping information up-to-date continues.

5. **Community partnership** projects funded in 2012/13 to support people with chronic conditions or mental health/substance use problems are the following:
    - ***Counseling Service for Patients with Complex Health Issues*** - individual and group counseling for individuals experiencing mild to moderate depression and chronic illness. Patients seen during the quarter: 12.
    - ***Peer Support for Health and Wellness*** - offers one-on-one emotional support, guidance regarding life changes and challenges, as well as provide resource information. Referrals received during the quarter: 30 who were provided 145 support hours.
    - ***North Shore Keep Well*** - an exercise and wellness program for mobile seniors to encourage and help older adults to keep well by leading active and independent lives. The program includes one hour of exercise followed by blood pressure checks and health coaching, massage, speakers and social times. Total attendees during the quarter in 7 sites: 1,750.
    - ***Golden Circle*** offers wellness and leisure education to frail seniors who may have challenges accessing programs. It includes out-trips, healthy snacks/social time, education speakers, brain and memory games, chair exercises and other recreational activities.
    - ***First Link*** a first response strategy for people newly diagnosed with dementia and their

families. It includes proactive outreach, information and connections, and planned follow-up. Project is in start-up phase.

3. Richmond

- Activities related to the Richmond IPCC Committee:
  - GPs had early discussions with Mental Health Services re "What information do GPs need regarding mental health services and how would they like to receive this information?"
  - Committee is in the process of reviewing/collating and identifying the status of the integration improvement ideas (45 ideas) identified at the future state mapping event. In the process of deciding which improvement idea will be next priority.
  - Committee received a presentation and update re the Care Conferencing initiative; a one pager communication handout has been developed to inform GPs of this initiative. Also invitation sent to IPCC GPs to participate as part of a working group and/or to care conference patients identified in their practice.
  - More active participation from the Division of Family Practice (DoFP) Coordinator re reporting back on DoFP activities related to integration.
  - One time funding proposal submitted to accelerate integration improvement initiatives CD Nurse Clinic; Seniors Resource List and Medication Management Initiative.
  - Orientation IPCC package prepared for HCC Managers communication tool to use as they are informing and communicating to their staff around IPCC related activities.

- The following improvements are being implemented to achieve integration of care:
  1. **Standard Referral Form and Long Term Care 1 (LTC1) Report** The objective is to streamline the referral process from GP to HCC and feedback to GPs. The HCC referral form has been redesigned and new HCC protocol implemented with 10 GPs involved. ***Stage of Project***: Spread which is currently being evaluated.

  2. **Screening-Tracking Tool for Frail Elderly** This one-page screener was developed with Family Physicians to use in their practice to actively case find frail elderly patients who could benefit from referral to Case Management (CM) service and to proactively identify clients who are not eligible for CM, but are at risk and may benefit from social supports and services available in the community. ***Stage of Project:*** Pilot testing phase completed with 4 GPs involved; in the process of planning for Spread which will be evaluated.

  3. **Medication Management** The objective is to create an accurate patient medication list to improve communication and interaction within the inter-professional team resulting in coordinated care, awareness of patient status and reducing duplication of work and frustration. ***Stage of Project*:** Pilot/Testing. The BC Patient Safety and Quality Council medication card or a similar card/patient health booklet is being tested by 9 GPs, aim is 20 GPs. Medication brochure has also been created to inform, empower, and make aware patients on importance of medication safety and keeping a medication list. Patients and Providers will be interviewed/surveyed in February at the end of the pilot phase.

  4. **Senior's Community Resource List and Key Community Agency Partnerships** The objective is to develop one resource list for GPs and other health care providers to use in their practice that includes non medical supports and services available in Richmond for seniors. ***Stage of Project:*** Pilot/Testing. Package that includes a Folder (Senior Resource List) and memory stick has been

completed and delivered for trial to participants including 4 GPs and 19 other care providers. Tracking sheet completed. Working with agency (Volunteer Richmond) to see if they can update resource list on an annual basis. Evaluaton of the utility of the list will be conducted in March.

5. **One Care Coordinator/CDN Clinic** The objective is to implement a CDN clinic; Nurses can provide support to GPs that do not have a CDN attached to their practice and whose patients with complex conditions that can benefit from the intervention/services provided by a CDN. ***Stage of Project***: Planning with 3 GPs involved. Project Charter has been completed; Masters student reviewing the literature on care models and a 3-day Lean session was held. Evaluators working with the team to develop evaluation plan.

6. **Community partnership** projects supported in 2012/13 are the following:
    - ***Wellness Connections Program*** - a transitional therapeutic recreation bridging program that enables frail isolated seniors and people with multiple chronic conditions to identify and master the skills for community recreation participation and community inclusion.
    - ***First Link*** a first response strategy for people newly diagnosed with dementia and their families. It includes proactive outreach, information and connections, and planned follow-up. The project is in the start-up phase.

4. Pemberton in Sea-to-Sky

- The Pemberton Committee continued to provide support and direction to the identified opportunities for improvement:
    - Development and pilot testing of the Pemberton Valley Community **resource directory**. Evaluation o f the utiity of the directory will occur in March.
    - ***Coming Together*** **event -** held on October 18th at Mount Currie to bring together the health staff from the Pemberton region and surrounding First Nations communities and provide an opportunity for them to get to know each other, share knowledge and information and increase awareness of the role of the IPCC Steering Committee. A total of 65 people attended. Evaluation of the event showed that over 95% of respondents said the event met its goals, was highly valuable, and will help us move forward in working together. As a result of the event, working groups have been formed that include the health staff, First Nations health staff and the physicians. These working groups will begin work on common critical issues.

- **Community partnership** project supported in 2012/13 is the ***Bowling for Life*** an opportunity for seniors of Pemberton and elders in Mt. Currie to come together for an afternoon of Wii bowling and lunch. Number of participants: 66

5. Downtown Eastside (DTES) Vancouver

- Activities related to project oversight and coordination:
    - DTES Working Group met on November 15 to discuss status of pilot implementation and address issues/challenges.
    - DTES Working Group also reviewed baseline evaluation report which includes results of patient and provider surveys, and data on ED visits, hospital admissions and clinic visits.
    - Additional resources were made available to the primary care sites. DCHC and VNHS received funding for a part-time nurse to carry out the tasks related to integrated care for high ED users.

- **Integrated care process for the high ED users -** High ED use clients refer clients who visited St. Paul's Hospital ED 10 or more times between April 1, 2011 to February 2012. The clients are going through an integrated care process that includes the following elements: registry, review of client file, identifying primary care lead, reviewing ED care plan, identifying other clinicians, meeting with client, case conferencing with client, developing a care plan, sharing the care plan and care plan follow-up. ***Stage of Project***: Pilot. Overall status in the five participating sites is as follows:
  - Number & % of clients with chart review completed - 60 or 86% of the 70 active clients in the target population.
  - Number & % of clients with primary care lead (GP or NP) identified 38 or 54%
  - Number & % of clients with ED care plan available/reviewed 14 or 20%
  - Number & % of clients with case conference held 2 or 3%
  - Number and % of clients with shared care plan created 2 or 3%

- **Primary Outreach Services Teams** continues to hold clinics in single occupancy hotels (SROs) and shelters providing mental health, addiction and primary care. They also provide ongoing case management and health care support to 700 clients.

- **Community partnerships** continue to be supported in SROs to provide tenancy supports through the non-profit organizations including: Raincity Housing and Support Society, and Portland Hotel Society Community Services.

- **Conference Presentations**: The work of this project has been presented at two recent conferences including the Accelerating Primary Care Conference in Banff (October) and the IHN Conference in December. A presentation on the project has also been accepted for the BC Quality Council Conference in February 2013.

6. Vancouver

Vancouver Community of Care has initiated projects that facilitate integration of care. They include:

- **Ideal Transition Home** The goal is to improve the patient and family experience and provide quality outcomes for patients discharged from VGH. The interventions are:

  Within 48 hours of admission:
  - *Readmission Risk assessment* score initiated (early identification of patients at moderate to high risk for readmission)
  - *Readmission Risk mitigation checklist* initiated (standardized interventions)
  - *Hospitalization notice* faxed to GP in community
  - *Referral* sent to community for known clients and for assessment for new clients

  And upon discharge:
  - *My Discharge Plan is* completed and given to patient/family and faxed to community and community GP (discharge notification fax).
  - *High risk patients* - Follow up GP appointment made prior to discharge for 48 hours post discharge.
  - *Moderate risk patients* Follow up GP appointment made prior to discharge for 3-5 days post discharge and a follow up phone call to patient/family by Care Management Leader 48 hrs post discharge.

Stage of Project: Spread phase.

- **GP care conferencing** This involves care conferencing between GP and VCH home health staff. ***Stage of Project***: Planning. A planning session with GPs has been held and being scheduled is a planning session with health care providers and managers.

Key Issues, Dependencies and Mitigation Strategies:

Issues/dependencies/barriers across communities:	Mitigation Strategy:
• Change of habit/routine/"old way" takes time.	• Develop realistic project timelines and change management strategy.
• Double charting when a VCH staff works in a GP practice.	• Support development of linked information system across care settings.
• Time of a VCH staff that is taken away from current practice when staff is assigned to a GP practice; or Time for providers to do the improvement work amidst regular duties and other initiatives being rolled out.	• Additional resources for backfill or additional part-time hours.
• Training of VCH staff in collaborative practice with GPs.	• Leverage on the Care Management project's planned staff training initiatives.
• Reaching out to more GPs to be engaged in integration projects.	• Continuous engagement and partnership with Divisions of Family Practice.
• Ho w to systematically address clients needing nonmedical supports.	• Incorporate into the Community Lead role the process of allocating IPCC funding for community partnerships to support nonmedical needs.

Successes and Lessons Learned:

Planning Change:

- Clear understanding of needs and clearly defined goals of each integration initiative before a pilot or trial must be described in detail.
- Time must be spent to clearly define and understand the new/redesigned process .
- Involve the MOAs early on in changes affecting a GP practice.
- Support of management is essential.
- Involvement of embedded developmental evaluator is critical at the planning stage of projects

Introducing Change:

- Continuous engagement of care providers in supporting an integrated approach to care.
- Clear communication across all stakeholders.
- Keep tools simple as FPs have little time during patient visit and listen to practitioner's feedback.
- Additional resources needed for staff time to do pilot testing work.
- Adaption of changes using available technology e.g. website option for those with no Smartphone and therefore cannot use the App for programs and services.
- Developmental evaluation provides timely reports and feedback which help with ongoing progress of the projects.

QUARTERLY REPORT (Section 2) – October 1, 2012 to December 31, 2012

	Community Based Service Delivery Areas	Communities included in CBSDA	Total Population of CBSDA	Version #[1] /stage planning & implementation	Division *-In place -In Progress -Not started*	# Family Physicians engaged (re ated to vers on/ terat on)	CSC *-In place -In Progress -Not started*	Target Population(s) *Name (i.e. frail elderly – home health) & Case definition*	# People in the Target Population *(estimate based on case definition - denominator)*	# Patients receiving new or redesigned services *(cumulative # of unique patients)*	% Reach[2]
1.	Powell River	Powell River	19,733	Testing improve ments	In place	2 in Steering Committee & 10 in various initiatives	In place	Very High & High morbidity with cardio-vascular disease or Mental Health & Substance Use problems	1,722	▪ Methadone clinic and Mental health counsellor - 13 ▪ Home care nurse and GP partnership - 20; ▪ Connecting Pregnancy - 24 ▪ At risk users/ presenters to ED - 90 ▪ Community partnership projects - 129	
2.	North Shore	North Vancouver & West Vancouver	186,776	Testing improve ments and spread	In place	2 in Steering Committee; & 53 in various initiatives	In place	Very High & High morbidity	17,906	▪ GP care conferencing – 50 patients; ▪ Chronic disease nurse coordinator – 61 ▪ Chronic Disease Nurse* in GP practices – 837 in regular caseload and 150 other patients ▪ Community partnership projects – 1,792	

[1] *Version # indicates progress using incremental improvements; if your HA uses a stages of implementation framework, please indicate that status/iteration)*

[2] *Reach = number of patients receiving services (cumulative count)/ number of patients in target population (actual as per case definition, or estimate)*

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 2) – October 1, 2012 to December 31, 2012

3.	Richmond	Richmond	189,027	Testing improvements & Spread	In place	15 in Steering Committee who are also involved in pilot/ testing	In place	Frail elderly: age 80+ and 70-79 with Alzheimer/ dementia	7,178	▪ Screening-Tracking Tool – 20 patients; ▪ Medication Card – 15 patients; ▪ Chronic Disease Nurses* in GP practices - 372 in regular caseload and 212 otherpatients	
4.	Howe Sound	Pemberton Squamish Whistler	33,458; Pemberton on y=5,118	Planning	In progress	2 in Pemberton IPCC Committee	In progress in Pemberton	Population in Mt. Currie Reserve and Southern Stl'atl'inx	1,800	Chronic Disease Nurse in GP practices – 51 from First Nations communities	
5.	Vancouver - Downtown Eastside (DTES)	Downtown Eastside Core	61,242	Testing improvements	In place	8 in IPCC Steering Committee and Working Group; 24 involved in the care of 89 patients	In place	Complex marginalized population	8,000 residents in DTES core; 89 High ED users of St. Paul's Hospital – visited 10+ during the year	• Integrated care process - 70 patients • 700 patients continued to receive services from the primary care outreach team in 16 Single Room Occupancy hotels (started under IHN)	
6.	Vancouver - Except DTES	All LHAs except DTES	568,663	Spread	In place	254 GPs of moderate to high risk patients	In place		Moderate to high risk patients	• Chronic Disease Nurses in GP practices* - 332 in regular caseload and 504 other patients	
7.	Sunshine Coast	Sunshine Coast	28,936		In place		In progress				
8.	Bella Coola Valley and Central Coast	Bella Coola Valley & Central Coast	4,290								

* Chronic Disease Nurses in GP practices under the IHN model will be combined with IPCC in the care model that the community decides.

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 3)

	Community Based Service Delivery Areas **2011/2012**	Collaborative Services Committee priority issues/ <List-may coincide with CSC agendas or IHN Steering Committee Agenda> Below are VCH Local IPCC Steering Committee agenda/issues:	Describe planned new or redesigned services (and % implemented) < describe **key integration** activities that are being prototyped; **include numbers of other providers** such as case managers, nurse practitioners etc >	Patients as Partners Specific examples of how this service delivery element is being embedded by CBSDA i.e. Patient/community partner on CSC; training etc	Care Planning - Coordinated / Shared Care Plans (key elements or, operational definition ; # shared care plans per GPSC billing fee)
1.	Powell River	▪ Sharing of information between GPs and VCH home health & mental health teams ▪ Shortage of Physicians ▪ Timely communication ▪ Shared care plan – eventually electronic ▪ Building community partnerships	▪ Methadone Clinic and Mental Health Counsellor ▪ Home Care Nursing and GP partnership ▪ Intake Liaison redesign ▪ Home health service redesign ▪ Connecting pregnancy (Interdisciplinary primary maternity care group visits) ▪ "At-risk" users/presenters to ED ▪ Community partnerships	▪ Patient representation in IPCC planning such as regional and local IPCC steering committees or working group ▪ Formal orientation of patient representatives before involvement in steering committees/working group ▪ Various ways of capturing patient voice such as patient survey, focus groups and patient journey mapping in improvement initiatives	Care planning is done as part of case conferencing between GP and community care providers e.g. case manager, home care nurse. Possible measure is: ▪ Patients in the target population who have a care plan in VCH's PARIS (Primary Access Regional Information System) or paper-based tracking system
2.	North Shore	▪ Proactive identification of high risk patients ▪ Linking GPs and VCH home health & mental health teams ▪ Building community partnerships	▪ GP care conferencing ▪ Home and Community Care intake redesign ▪ Chronic Disease Nurse Coordinator ▪ Smart phone app on programs and services ▪ Community partnerships	Same as above	Same as above
3.	Richmond	▪ Proactive frailty assessment of all people age 80+ ▪ Improved communication and interaction of among team of care providers	▪ Standard referral form for all home health services and LTC 1 assessment report to GPs ▪ Screening-Tracking Tool for the frail elderly ▪ Medication management ▪ Senior's Community Resource List and Key Community Agency Partnerships	Same as above	Same as above

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

			▪ One care coordinator/CDN Clinic ▪ Community partnerships		
4.	Howe Sound - Pemberton	▪ Building on integration practices in current system ▪ Integration between services at Pemberton Health Centre and Mount Currie and Southern Stl'atl'inx Health Centres	▪ Coming Together event ▪ Community partnership	Same as above	Same as above
5.	Vancouver - Downtown Eastside (DTES) Core	▪ Targeting high ED users to reduce their Ed visits ▪ Integration of care processes ▪ Efficient proactive community-based care	Integrated care process that has the following elements: ▪ Creating a registry ▪ Reviewing the client file ▪ Identifying the primary care provider ▪ Reviewing care plan in St. Paul's Emergency Department ▪ Meeting with client to understand reasons for going to ED and get inputs in goal setting ▪ Case conferencing including the client ▪ Developing a comprehensive care plan ▪ Sharing the care plan ▪ Following-up on care plan	Same as above	Same as above
6.	Vancouver – Except DTES	▪ Transitions and care coordination to primary and community care providers for patients discharged from acute care	▪ Ideal Transition Home initiative ▪ Care conferencing	Same as above	% of time transition plan transferred with patient (Mod/high risk)

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

INTEGRATED PRIMARY AND COMMUNITY CARE

QUARTERLY REPORT (Section 1)

Health Authority : Vancouver Coastal Health	Reporting Period: March 16 to June 15, 2013
Compiled by: Venie Dettmers	Submitted to MOH: June 21 , 2013

Summary of Major Progress and Key Accomplishments Since Last Report

Macro (across HA):

A. Accelerated Integrated Primary and Community Care Initiative (aIPCC)

In addition to integration projects under the IPCC bilateral agreement, the projects listed below are being implemented with Accelerated IPCC funding starting. Separate progress reports are submitted to the Ministry, however, an evaluation report on the results of a provider survey in six projects is included in this report.

- ***Avoidance of Unnecessary Residential Care and Acute Admissions (AURAA)*** Provides an enhanced home based service to clients who would otherwise be moved to residential care. Care is provided by an interdisciplinary team with the following focus: intensive care management and an enhanced mix of community-based services designed to meet the needs of clients with multiple, complex and interacting chronic diseases and/or social and environmental factors.

- ***Early Supported Discharge*** In collaborative partnership with GPs, an interdisciplinary community reintegration team supports patients with COPD, CHF and stroke through an early discharge from acute care. The team provides short term rehabilitation for up to three months that includes: coordination, education, and provision of self-care management education and support to patients and caregivers to enable them to have knowledge and skills needed to manage their chronic condition.

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- ***Acute Home Based Treatment (AHBT)*** Provides home-based treatment for mental health and addictions clients as an alternative to hospitalization. The AHBT team consists of psychiatrists, clients, families, GPs and nursing staff supported by social workers, counsellors, or rehabilitation professionals as required. This team follows clients and provides intensive short-term treatment for up to 21 days in the clients' home.

- ***Care Management/Home Health Redesign*** Aims to redesign VCH Home Health services to align with the provincial care management strategy and integrate teams with primary care in each community. The components are inter-professional care conferencing between GP and home health team members and telephonic care management.

- ***Assertive Community Treatment (ACT)*** A client-centered, recovery-oriented mental health service delivery model, the ACT team is mobile and delivers services in community locations to enable clients to continue to live in their community. This service is provided 24 hours a day by a

multidisciplinary team, including a GP, with a low client to provider ratio. The expansion of ACT teams is in its early phase.

- ***Provider Survey*** Survey in January 2013 of VCH staff providers involved in any aIPCC project showed that key successes identified are: team work/working with other health care providers, patient satisfaction, GP engagement, fewer ED visits, reduced admissions, decrease in length of stay and increase in discharge capacity. Attached below is the overall summary released in April.

B. Other Region-wide Integration Initiatives

- ***First Nations/Aboriginal Initiative –*** The goal of the initiative is to facilitate the integration of the First Nations and Aboriginal services with the IPCC work. A VCH-IPCC Aboriginal/First Nations advisory team facilitates engagement with First Nations and community members to develop local vision and priorities for IPCC. A Regional working group meets regularly and consists of members of the Regional IPCC Team: Director, all Change Leads, aIPCC Project Manager, and the Manager of Evaluation along with representatives of the VCH Aboriginal Team, a representative from the First Nations Health Authority and members of the VCH-IPCC Aboriginal/First Nations advisory team. Highlights during the reporting period are:
  - The First Nations health directors have signed off on the inventory/map of primary care services for all 14 First Nations communities in VCH. The inventory/map has been presented to the VCH Senior Executive Team and provincial Implementation Leadership Committee. A communication and roll out plan of the map is being developed.
  - An inventory/map of services used by Aboriginal people off-reserve/urban areas is being developed.
  - First Nations Health Directors from Sliammon, Mt Currie & Southern Stlìtlìmx Health Society, and Squamish & Tsleil-Waututh First Nations are members of local community IPCC steering committees in Powell River, Pemberton and the North Shore, respectively. Joint IPCC initiatives involving physicians are occurring in the North Shore and Pemberton. Joint discussions are beginning in Powell River.
  - Reflections/survey on First Nations/Aboriginal Initiative Progress was sent to key stakeholders in early June.

- ***Regional Intensive Complex Patient Care Planning (RICP2) Initiative –*** The goal is to create a regional care planning process that ensures a comprehensive approach to caring for patients who frequently visit or use the Emergency Department for complex and/or chronic care management issues. The focus is on people who visited urban EDs 20+ times during the year.
  - Baseline data was established on health utilization of familiar faces, patient experience and health provider (staff & physician) experience.
  - Current state and future state mapping were completed with the five hospitals participating.
  - A total of 16 familiar faces have been identified to be involved in a care plan managed by

a health provider in the community. A care plan tool will be developed by end of June. Plan-do-study-act period is June to September. Further evaluation will occur September-October.

- ***Updating of the VCH Integration and Performance Measurement Framework*** The goal is to update the overarching VCH integration framework based on work to date and on the emergent future state to guide ongoing work. Key elements and best practices are being identified along with indicators of progression toward an integrated system. An overall regional and community level evaluation plans will be developed in conjunction with this regional framework by September of 2013.

Meso and Micro (for specific populations or patient groups; by CBSDA):

1. Powell River

- Powell River IPCC Steering Committee A change in leadership has occurred with the retirement of their Director. An interim director is in place and a new Director for VCH Powell River has been hired effective September 2013. Also, new Health Director for Tla'amin nation, Cynthia Jamieson, has joined the steering committee.

- Physician Engagement Strategy The IPCC Steering Committee held a session on May 23rd to engage family physicians in integration work and provide an update on the integration initiatives. A total of 11 physicians attended, representative from Tla'amin nation, and VCH staff. Evaluation of the evening showed that the event was very successful. A two page report is attached.

Summary Report of
May 23 World Cafe 0(

- The following improvement projects are being implemented to achieve integration of care:

1. **Intake Liaison Redesign Integration Initiative** The objective is to develop a more streamlined and efficient referral process from primary care to Home and Community Care (HCC). ***Stage of Project: Planning.*** With the collaboration of Practice Support Program (PSP), Physician Information Technology Office (PITO) and VCH, a new system of referral from Primary Care to Home and Community Care that mimics e-referrals from Electronic Medical Record (EMR) is being implemented. Evaluation in May of earlier form/process provided important feedback to the working group for next steps. New form is scheduled to be implemented first week of July. Family physicians and MOA's will be provided with in-service on where to access the form in the Electronic Medical Record and patient information that needs to be included with the referral. Data will be tracked for 3 months post implementation to ensure compliance with the new process.

2. **Home Health Service Redesign** To better meet the need of clients, changes in practice of Home and Community staff are being implemented as part of the Care Management Strategy. ***Stage of Project***: ***Planning***. Future state map for the six populations of home health clients has been developed. The five population groups identified are: Chronic Co-Morbid; End of Life/Palliative; Adult Living with Significant Disability; Post Surgical/Episodic; and

Frail/Complex Older Adult/ Dementia. There are 99 improvements of which 30 are categorized as high priority. A drafting group has been formed to work on the 30 improvement ideas. Priority work bundles are to be completed by June 30, 3013.

3. **Connecting Pregnancy Program** The objective is to develop a rural model of interdisciplinary primary maternity care. The program is co-facilitated by a family physician who provides individual prenatal care during the sessions and a public health nurse. Guest speakers provide added information. A group of six to eight women and their partners attend 9 group sessions over 18 weeks (every other week). Three cohorts have participated thus far and a fourth cohort is ongoing. ***Stage of Project: Spread***. An evaluation report (2011-2012) has been completed. Both a long version and a two pager (attached below) were produced. Next step for the project is to determine how to engage more physicians.

Eval Summary Report of Connecting

4. **"At Risk" Users/Presenters to the ED** The objective is to better respond to "at-risk" or “high use” patients whose care can be improved by better coordination through the Powell River Hospital Emergency Department. The focus is on the following areas:

- **Chronic Disease (Acute Exacerbation):** A direct referral service for patients presenting to the ED with an exacerbation of one of three chronic diseases {CHF, CKD or COPD} to CDM RN services at 5 GP clinics is in progress. ***Stage of Project*: *Pilot/Testing.*** Pilot of current PDSA has concluded and study and action planning is underway. Analysis shows that patients presenting to ED are admitted as inpatient.

- **Mental Health or Addictions Crisis:** A new algorithm of standard practice is being applied in the ED for patients presenting with Mental Health or Addictions concerns that includes a Psychiatry Nurse coming to the ED and assess each patient upon notification from ED. ***Stage of Project: Spread***. All patients with mental health or addictions crises are now receiving the redesigned care approximately 1 patient per day. Evaluation of this change in practice is to begin.

- **Chronic Pain:** Current practices of treating patients with chronic as well as acute chronic pain episodes in the ED are being reviewed. ***Stage of Project: Planning***. A physician has been engaged into discussion as a referral pilot to treat patients with chronic pain. Further investigation regarding TeleHealth options connecting with regional chronic pain supportive options are being followed up. Further analysis of patients presenting is underway.

- **Acute Pain:** A change in practice for providing more appropriate first-time pain control to patients presenting with acute pain is being assessed/reviewed. ***Stage of Project*: *Planning***. Discussions regarding RNIA (Registered Nurse Initiated Action) are ongoing as one of the possible pilots. Powell River is potentially a pilot site for RNIA narcotic administration to improve pain control for patients in ED.

- **Falls Prevention:** Collection of demographic information on clients presenting with falls

to the ED has begun. ***Stage of Project*: *Planning***. A re-visit of SAIL (community health falls initiative) and how this may be adapted to Acute is currently being done. Included in home health redesign also.

- **Rapid Process Improvement for Patients with No Family Doctor** A workshop was held in March to reduce the number of ED visits by patient with no family doctor (NFD) and ensure that comprehensive care is provided to patients right care for the right patient in the right place at the right time. There were 27 improvement ideas identified of which nine have been completed. Patients with NFD are being flagged at admission. Upon discharge, NFD's are encouraged to use the Primary Health Care Clinic in Ambulatory Care that operates once a week for five hours. ***Stage of Project*: *Pilot.*** Work in progress includes flagging patients at admission who are known to Home Health and Mental Health, introducing discharge summary and care plan form to ED staff to PDSA, educate ED staff on community referrals and resources, educate ED staff on Home Health referral and general information on Home Health services, option to access Home Health staff or care plan for known patients who present to the ED, initiate rapid access with Home Health, NFD patients leaving ED with a primary care provider.

5. **Health Resource Navigator –** The objective is to assist physicians in identifying available health and social support services and linking patients to these services. The Resource Navigator will be responsible for sourcing available community, regional, and provincial health and social support services and will determine the best method of keeping up-to-date listings of these services and the best methods of communicating this information to physicians. The navigator will support physicians in linking patients to the most appropriate service. ***Stage of Project: Planning***. Resource Navigator has been hired effective May 15, and has started to meet with community programs and physicians. Evaluation plan has been developed.

6. **Integrated Practice Support Initiative (IPSI) Powell River Initiative** The objective is to strengthen the delivery of quality practice support by aligning PSP and PITO practice support services. This local initiative is lead by the Division of Family Practice (DoFP) and the IPCC evaluator has been invited to provide evaluation work and the Powell River Change Lead has been asked to join the IPSI Committee. Evaluation activity is on-going and will culminate in a final evaluation in the fall of 2013.

7. **Community partnership** projects funded in 2013/14 and their status based on last available report are the following:

   - ***Building Recovery of Individual Dreams & Goals through Education (BRIDGES)*** provided by the BC Schizophrenia Society a course taught by consumers for consumers to empower people with tools that will help them in their journey to recovery. Meetings are held the third Monday of each month from 7:00 to 8:30 pm, in the meeting room on the third floor of the hospital. Bridges program is partnering up with the Community Resource Centre (Monday Brunch Program) to hold workshops in July for patrons suffering from depression.

   - ***Humble and Hearty Workshops*** provided by Powell River Employment Program Society offers a series of 18 workshops focusing on the preparation of low cost nutritious

meals designed to include ingredients realistically accessible to low income people, specifically what is available from local free food resources.

Number of workshops held during the third quarter: 6 with 47 referrals received. Feedback from participants continued to show extremely high ratings. Participants said they used the recipes and greatly enjoyed the food, the participatory atmosphere, and the knowledgeable facilitators.

- ***Monday Brunch*** provided by Powell River Employment Program Society - provides access to meals with fresh fruits and vegetables for people with chronic health problems, and facilitates access to public health professionals and other educational and social supports.

  Number of brunches offered during the quarter: 10 with an average of 40-60 participants. A public health nurse was in attendance during the brunch five times and social support is always available from staff and peer support.

- ***Promoting Community Wellness*** provided by The Source Club Society - provides people living with mental illness with social and recreational activities, and opportunities to engage in healthy practices. Number of workshops conducted: 24 with 26 referrals. This year's Yoga Program continues to support the participants' needs for mental and physical fitness. Attendance is very good. Many are coming because they are feeling the benefits of breathing deeply, core strengthening, stamina building and other benefits of Yoga.

2. North Shore

- The following improvements are being implemented to achieve integration of care:

1. **GP Care Conferencing** Care conferencing in person or over the phone between Home and Community Care (HCC) staff was rolled out beginning of October. This rollout builds on the pilot testing of care conferencing with case managers in late winter/spring 2012. ***Stage of Projec***t: ***Spread***. Process has been rolled out to all HCC clinicians. Workflow has been established and clerical support implemented to arrange conferences for clinicians. To date, 122 clients have had care conferences conducted on their case. In total 70 GPs have engaged in care conferencing with 42 HCC staff.

   An evaluation of this initiative took place in April 2013, with 26 Home Health Clinicians, 10 General Practitioners, and two program clerks taking part in the evaluation. Evaluation results showed that majority of GPs and home health clinicians surveyed said that conferences improved patient care and their ability to deliver quality care. The one page evaluation summary is attached below.

NS GP Care
rencing Two

2. **Home and Community Care Intake Redesign** In response to a Lean analysis recommendation, an intake clerk position was created to reduce the amount of non-clinical administrative work such as faxing, collecting demographic information by intake nurses, and having 'live' clerical support answering calls. ***Stage of Project: Sustainment***. As of December 2012, a new workflow has been established in order to reduce the bottleneck of referrals and increase feedback and communication to GPs on the status of the referral to Home & Community Care.

   An evaluation of the changes took place in March and April 2013. Twenty eight Home Home clinicians and 11 General Practitioners took part in the evaluation, which demonstrated that the time to process referrals had greatly decreased. The two page evaluation summary report is attached below.

   

   North Shore
   ake Evaluatior

3. **Chronic Disease Nurse Coordinator Program** The objective is to engage family physicians to refer their patients with two or more chronic conditions for comprehensive guideline-based care to the Chronic Disease Nurse Coordinator who will support and help manage their chronic conditions. A key change idea for this program is that the CDN Coordinator is housed in a central location at a Community Health Centre rather than embedded in a Family Physician's private practice ***Stage of Project: Spread***. With continued spread of program communiqué, client brochure, and dissemination of evaluation results, the number of referrals continues to steadily increase. As of early June 2013, a total of 87 clients from 26 different GPs were referred with 64 active clients. The CDN is also now "live" in PARIS. PARIS documentation is currently limited to allocation of CDN to clients; this is being done to ensure Home Care, the Geriatric Outreach Program, and other VCH teams are aware of the CDN's involvement in mutual clients care.

   The evaluation of this program was completed in late March 2013. Findings showed a 52.7% decrease in emergency room department visits and a 76.0% decrease in hospital admissions six months after first being seen at the CDN clinic. Patients and General Practitioners were extremely pleased with the clinic and the services it provides. The two page evaluation summary is attached below.

   

   Chronic
   se Nurse Evalı

4. **Smart Phone App** The objective is to make information about programs and services that support the health and wellness of the North Shore population accessible to physicians and their MOAs. A directory of physicians indicating their specialty will also be incorporated into the App and its web-based version (the latter intended for those without a smartphone). ***Stage of Project: Pilot/Testing.*** The March release of the mobile app was tested with some outstanding issues and bugs identified. The developers are working to resolve all reported bugs and continue to further polish the app before the next scheduled release date in June. Website content for home page, contact us, etc. has also been drafted and program entries revised to be more user-friendly; testing of the website version will continue once coding has been refreshed/updated

by developers in June.

5. **High Needs Clinic** The objective is to establish an integrated primary care clinic that will provide health care services to vulnerable North Shore residents with complex medical, mental health and/or socio-economic challenges and have no GP or a loose attachment to a GP. This clinic is a partnership between North Shore Division of Family Practice and VCH. ***Stage of Project: Development/Implementation***. A Steering Committee was established with representation from both partners; sub-committees have also been developed for operations, staffing, communications, clinical/policy/planning and evaluation needs. A charter, MOU and communication materials have been drafted. Clinic space has been secured for five mornings a week (Monday-Friday) with a family physician, nurse practitioner, chronic disease nurse coordinator and medical office assistant available on specified days. In addition, the clinic is partnering with community agencies to support clients who require assistance with non-medical issues such as housing, income, and access to food. The clinic opening is slated for July 2, 2013.An evaluation plan is being developed.

6. **First Nations Working Group (North Shore/Coastal) –** The purpose of this working group is to improve linkages and communication among First Nations Health Centres, Lions Gate Hospital, Primary Care and Mental Health & Addictions.

7. **Integrated Practice Support Initiative (IPSI) North Shore Initiative** The objective is to strengthen the delivery of quality practice support by aligning PSP and PITO practice support services. The lead evaluator from the IPCC Regional team has been asked to be involved with the local IPSI initiative that is lead by the DoFP. Evaluation activity is on-going and will culminate in a final evaluation in the fall of 2013.

8. **Community partnership** projects funded in 2013/14 and their status based on last available report are the following:
   - ***Counseling Service for Patients with Complex Health Issues*** - individual and group counseling for individuals experiencing mild to moderate depression and chronic illness. Number of referrals received: 21; Patients seen during the quarter: 12.
   - ***Peer Support for Health and Wellness*** - offers one-on-one emotional support, guidance regarding life changes and challenges, as well as provide resource information. Number of intakes from community: 7 who were provided 100 support hours.
   - ***North Shore Keep Well*** - an exercise and wellness program for mobile seniors to encourage and help older adults to keep well by leading active and independent lives. The program includes one hour of exercise followed by blood pressure checks and health coaching, massage, speakers and social times. Total attendees during the quarter in 7 sites: 2,923.
   - ***Golden Circle*** offers wellness and leisure education to frail seniors who may have challenges accessing programs. It includes out-trips, healthy snacks/social time, education speakers, brain and memory games, chair exercises and other recreational activities. Total number of participants for the quarter: 338
   - ***First Link*** a first response strategy for people newly diagnosed with dementia and their families. It includes proactive outreach, information and connections, and planned follow-up. Minds in Motion for North Shore and Vancouver: 5 locations in progress with 83 registered participants.

4. Richmond

- Activities related to the Richmond IPCC Working Committee:
  - April/May Working Committee meetings included comprehensive reflection on the work that was accomplished in the last two years, evaluation results available to date and discussion of next steps.
  - Practice Support Program (PSP) Lead and Richmond Integration Lead are working in closer partnership around IPCC initiatives. For example
    - PSP has embedded information re on GP Care Conferencing at End of Life Module/education session.
    - PSP accompanied CD Nurses to inform 2 GP practices re launching of new Chronic Disease Management Clinic.
    - PSP is available to help GP practices build the screener tool and GP Care Conferencing into their workflow.

  - DoFP Executive Director, Richmond Integration Lead and PSP Lead meet monthly to discuss opportunities for partnership. A key element that is being discussed is holding an MOA event that will highlight some of the tools developed through IPCC and provide a better understanding to MOAs.

- The following improvements are being implemented to achieve integration of care:

1. **Standard Referral Form and Long Term Care 1 (LTC1) Report** The objective is to streamline the referral process from GP to HCC and feedback to GPs. The HCC referral form has been redesigned. ***Stage of Project***: ***Spread to all the 130 GPs***. Tracking results (from Manager, Office Administrator) indicate referrals forms are being completed appropriately; very little error or misses. An evaluation plan is being developed.

2. **Screening-Tracking Tool for Frail Elderly** This one-page screener was developed with Family Physicians to use in their practice to actively case find frail elderly patients who could benefit from referral to Case Management (CM) service and to proactively identify clients who are not eligible for CM, but are at risk and may benefit from social supports and services available in the community. ***Stage of Project: Spread***. This tool was presented to the AGM DoFP; a package containing the tool was distributed to all the 60 GPs attending the AGM. In addition, this same package was mailed to 60 GPs that are registered with DoFP but did not attend the AGM. An evaluation plan, including tracking system is being implemented.

3. **Medication Management** The objective is to create an accurate patient medication list to improve communication and interaction within the inter-professional team resulting in coordinated care, awareness of patient status and reducing duplication of work and frustration. ***Stage of Project*: *Pilot/Testing.*** The BC Patient Safety and Quality Council medication card is being tested in 15 GP practices. The pilot phase has been extended to the end of June; at this time patients and providers will be interviewed/surveyed. In addition a survey is being conducted among Richmond Community Pharmacists regarding the list of services that their pharmacies provide to patients. The information gathered will be used to inform GP practices, Home Health Clinicians and patients.

4. **Senior's Community Resource List and Key Community Agency Partnerships** The objective is to develop one resource list for GPs and other health care providers to use in their practice that includes non medical supports and services available in Richmond for seniors. ***Stage of Project: Spread***. This resource folder was showcased at the AGM 22 GPs attending the AGM signed up to receive a copy of the folder. The working committee is in the process of making the final changes by the end of June and me have the resource folder delivered to the GPs who have signed up to receive a copy and also to VCH clinicians in community, mental and acute care. Volunteer Richmond has accepted a role in updating the information each year starting next year.

   A health provider survey was conducted and results showed that 93% of health providers surveyed rated the List as useful.

5. **Chronic Disease Management Clinic** A Chronic Disease Management clinic is located at 8100 Granville with the objective to engage GPs in referring patients with chronic conditions for comprehensive guideline-based care to a centrally located clinic whereby Chronic Disease (CD) Nurses will support patients manage their health conditions. A key change is that CD Nurses can provide support to GPs who DO NOT have a nurse attached to their practices. ***Stage of Project***: ***Pilot***. Four Family Physicians Practices have been approached. As of April 2013 9 patients have been seen. Once, the Chinese brochure has been completed, the 2 other GP practices with a high Chinese speaking patient profile will be engaged.

6. **GP Care Conferencing –** GP Care conferences initiative was launched in February 2013. They are scheduled in advance with the GP, thereby ensuring that all participants in the conference have dedicated time to focus on the patient's needs. A working group with GPs and Home Health staff has been formed to work on process steps, to address issues as they come up and to determine how to share and communicate information regarding care conferencing to Richmond GP Practices. ***Stage of Project***: ***Spread***. To date, 59 clients have had care conferences.

7. **Early Supported Discharge -** The objectives are to support early discharge of clients with chronic conditions from acute care; support and improve patient self-management of chronic conditions. ***Stage of Project***: ***Spread.*** An interprofessional working group for Richmond has been established to lead and facilitate the embedding of patient input and experience, family physician input regarding process and delivery, and carry out a robust evaluation. A GP focus group and a patient focus group are being scheduled at the end of the month and in fall respectively.

8. **bestPath –** (Person-centred, Appropriate, Timely Healthcare) has recently been launched by VCH-Richmond. bestPATH is a partnership between Richmond acute teams, community teams and primary care to improve health outcomes; improve the care experience for our patients and clients; and improve workflows and the experience for care providers. ***Stage of Project***: ***Spread.*** The bestPATH strategy will roll out in phases starting with the 3 South acute unit team and South community team. Phase I will involve developing a better understanding of the current environment and identify opportunities for improvement with input from all care providers, patients/clients and families. Phase II will see the Steering Committee and Working Groups implement the solutions that have been identified.

The focus of IPCC is ensuring the primary care lens is included. Three Family Physicians attended 3 workshops held in May to provide input from a GP perspective regarding the current process as the patient journeys from Acute to Community and Primary care. The maps that were completed during these sessions will be validated by Richmond IPCC GPs at the upcoming meeting to be held on June 21st. Two hospitalists have been engaged to participate and provide input as well. At the end of June/July, GPs and Hospitalists will be invited to the Future State events.

9. **Community partnership** projects supported in 2013/14 are the following:
    - ***Wellness Connections Program*** - a transitional therapeutic recreation bridging program that enables frail isolated seniors and people with multiple chronic conditions to identify and master the skills for community recreation participation and community inclusion.

4. Pemberton in Sea-to-Sky

- The Pemberton Committee continued to provide support and direction to the identified opportunities for improvement:
    - Work with First Nation in Mt. Currie to find opportunities to improve integration of services with VCH.
    - Telehealth - E20 units have been installed in communities. The use of the units will be piloted until late summer. Evaluation of the pilot will occur in August-September.
    - Transportation services - inventory phase ongoing.
    - Development of a tool to educate staff at Lions Gate Hospital about Pemberton and surrounding area when discharging patients - pilot started in June. Evaluation will occur in August.
    - Nurse Practitioners are being hired.
    - Mount Currie is hosting a cultural day for VCH staff on June 27th.

- **Community partnership** project supported in 2013/14 is the ***Bowling for Life*** an opportunity for seniors of Pemberton and elders in Mt. Currie to come together for an afternoon of Wii bowling and lunch. Number of participants: 66

5. Downtown Eastside (DTES) Vancouver

- **Integrated care process for the high ED users –** The objective is to improve care coordination and proactive community-based care planning for clients who visited St. Paul's Hospital ED 10 or more times between April 1, 2011 to February 2012. There were 89 such clients at the start of the project. Five community sites and St. Paul's Hospital ED are involved in the project. The clients are going through an integrated care process that includes the following elements: registry, review of client file, identifying primary care lead, reviewing ED care plan, identifying other clinicians, meeting with client, case conferencing with client, developing a care plan, sharing the care plan and care plan follow-up. ***Stage of Project***: ***Pilot***. To date, there are 54 active clients in the cohort. Overall status is as follows:
    - Number & % of clients with chart review completed - 54 or 100% of the active clients in the cohort.
    - Number & % of clients with primary care lead (GP or NP) identified 44 or 81%
    - Number & % of clients with ED care plan available 28 or 52%
    - Number & % of clients whose other associated clinical teams have been identified 43 or 76%
    - Number & % of clients with case conference held 15 or 28%
    - Number and % of clients with shared care plan created 25 or 46%

- Activities related to project oversight and coordination by Steering Committee and Working Group:
  - Steering Committee met in April and reflected on learnings in piloting the integrated care process. It was decided that a best practice guidance document be prepared based on the learnings to inform in a timely manner the discussion on the DTES Second Generation Strategy whose vision in integration of care, and the Regional Intensive Complex Patient Care Planning Initiative (RICP2) which focuses on familiar faces in ED.
  - Working Group met in May and shared best practices and lessons learned in implementing each component of the integrated care process. These will be included in the best practice document.
  - Community sites have started transitioning the project work to everyday work in May. Steering Committee and Working Group role in promoting service integration will also be transitioned to existing relevant committees/groups.
  - A provider survey and focus group will be conducted as part of the evaluation.

- **Primary Outreach Services Teams** continue to hold clinics in single occupancy hotels (SROs) and shelters providing mental health, addiction and primary care. They also provide ongoing case management and health care support to 700 clients. ***Stage of Project: Sustainment.***

- **Community partnerships** continue to be supported in SROs to provide tenancy supports through the non-profit organizations including: Raincity Housing and Support Society, and Portland Hotel Society Community Services.

6. Vancouver

Vancouver Community of Care has initiated projects that facilitate integration of care. They include:

- **Ideal Transition Home** The goal is to improve the patient and family experience and provide quality outcomes for patients discharged from VGH. The interventions are:

  Within 48 hours of admission:
  - *Readmission Risk assessment* score initiated (early identification of patients at moderate to high risk for readmission)
  - *Readmission Risk mitigation checklist* initiated (standardized interventions)
  - *Hospitalization notice* faxed to GP in community
  - *Referral* sent to community for known clients and for assessment for new clients

  And upon discharge:
  - *My Discharge Plan is* completed and given to patient/family and faxed to community and community GP (discharge notification fax).
  - *High risk patients* - Follow up GP appointment made prior to discharge for 48 hours post discharge.
  - *Moderate risk patients* Follow up GP appointment made prior to discharge for 3-5 days post discharge and a follow up phone call to patient/family by Care Management Leader 48 hrs post discharge.

  Stage of Project: Spread phase. The estimated number of patients that have been discharged through the ITH process since the implementation in February 2012 to mid June 2013 (15.5 months) is: High Risk = 1,600 and Moderate Risk = 2,335.

- **Care Conferencing –** The objective is to better coordinate care between GP and home health staff.

Stage of Project: Spread. Implementation has just started.

- **Community partnership** supported in 2013/14 and their status in the previous quarter (January-March 2012) are as follows:
  - ***Development of COPD-related Educational Materials with an Appropriate Assessment of Health Literacy and Ethnic Needs (BC Lung Association*) –** The objective is develop, based on inputs from patients and front line health workers, educational materials in English, Mandarin, Cantonese, Farsi, Korean and Filipino to address specific issues such as: Mode of action of medications; How to use different inhaler devices; The role of action plans in COPD; The importance of pulmonary rehabilitation and the key components that a patient may expect to learn; and A patient information sheet to be provided to patients after they have had a COPD exacerbation either after a hospitalization or visit to the Emergency or an exacerbation managed by their primary care physician in the community.

    Community facilitators from Mandarin, Cantonese, Korean, Filipino and Farsi communities were recruited. Educational materials (that have already been developed by the team) and focus group materials were sent to the facilitators for translation. GP and patient recruitment is underway.

  - **Strengthening Community-based Resources for Families Experiencing Perinatal Depression and Anxiety and Their Health Care Providers (Pacific Post Partum Support Society (PPPSS)) –** Information gathered and recordings from patients and healthcare professionals and community support workers will be used to: a) Streamline existing distribution mechanisms for PPPSS resource materials. b) Create new culturally appropriate content for the Chinese, Farsi, Punjabi, and Spanish language informational brochures (Farsi and Spanish brochures do not currently exist). c) Update PPPSS training materials for community-based health care professionals, including the use of video interview segments designed to reduce stigma. d) Make the PPPSS website more engaging, interactive, and culturally appropriate, including the use of video interview segments designed to reduce stigma.

    Six of eight focus groups were completed mixed multicultural, Spanish. PPPSS alumni, Chinese, Dads and Punjabi speakers. Primary care physician interviews have started.

  - **Access For All – Supported Health & Wellness Program (Langara Family YMCA) –** The objective is to provide VCH clients with opportunities and support to improve physical activity and develop exercise habits and healthy lifestyle behaviours. The priority target groups will be clients deemed as high risk for exercise cessation. This project builds off of the current and successful Access For All model while incorporating a consistent, detailed and thorough support and follow-up component.

    YMCA internal procedures and trainings have concluded and intake documents revised. Clients taken in effective June 1.

  - ***First Link*** a first response strategy for people newly diagnosed with dementia and their families. It includes proactive outreach, information and connections, and planned follow-up. In order to ensure that services appropriate to people with early symptoms of dementia are available in the community, Minds in Motion™ and Shaping the Journey: living with dementia™

are implemented alongside First Link®.

- Number of referrals received during the quarter - 49 with majority coming from assessment clinic/specialist.
- Number of active cases 89
- Number of Minds in Motion Participants 98
- Number of participants in Caregiver Series (Cantonese only) 52
- Outreach to health professionals/Number of meetings and presentations) - 82

Key Issues, Dependencies and Mitigation Strategies:

Issues/dependencies/barriers across communities:	Mitigation Strategy:
▪ Slow down in uptake of improved process e.g. care conferencing numbers either remaining stable or slightly reducing	▪ Integration Lead met with the local/regional director regarding the issue. ▪ Integration Lead met with the Team Leads to discuss how the Lead could assist e.g. in case finding for care conferences.
▪ Home Health Redesign initiative is unfolding and at the fore front.	▪ Ongoing communication with staff is key; focus on providing information on how components of home health aligned and help to leverage the work of IPCC.
▪ Clinical System Transformation (CST) initiative has caused some concern among Family Physicians as the perception is that CST is not addressing timely communication with Primary Care.	▪ Invite the CST Senior Leader to come and speak at the IPCC tables to provide information as well as to take the time to listen to GPs concerns. This will help build trust, keep them engaged and may also help to shape the outcomes of CST.
▪ Physical distance between First Nations communities and VCH health centres	▪ Explored/facilitated the use of telehealth facilities
▪ Physician engagement to create buy-in for integration improvements	▪ Meet with physicians to help them understand IPCC and current work and to listen to their ideas on ways they can be involved.

Successes and Lessons Learned:

- Change takes time.
- Leadership is key to the success of an initiative.
- Collaboration in coming up with solutions within the limits of community resources.
- Change in leadership is difficult e.g. Home Health. It takes time to build relationships and trust. Momentum and direction may be affected.
- Project focus on high ED use does not resonate with community health providers whose major concerns are quality of care and patient outcomes.
- Tools help facilitate introduction of improvements such as care plan template.
- At some point a decision has to be made to complete pilot phase and transition project work to everyday work.

PRESENTATIONS

- Gillam, C, Berg, S, Brown, D, Ringaert, L. (May, 2013) "Clash of the Titans: Integrating Primary and Community Care". Canadian Association of Health Services and Policy Research Annual Conference. Vancouver, BC.
- Smith, T, Ringaert, L., Tice S., Oyedele, S, Tillotson, S. (June 2013). The British Columbia Healthcare System's Monitoring, Evaluation and Learning System: Going Where No Evaluators Have Gone Before". Canadian Evaluation Society Annual Conference. Toronto, Ontario.
- Ringaert, L. , Gillam C., Park C., Simpson D., Redfern K (June 2013). " Helping Healthcare Teams in Transformation: The Embedded Developmental Evaluator's Role" Canadian Evaluation Society Annual Conference. Toronto, Ontario.

QUARTERLY REPORT (Section 2) –March 16, 2013 to June 15, 2013

	Community Based Service Delivery Areas	Communities included in CBSDA	Total Population of CBSDA	Version #[1] /stage planning & implementation	Division *-In place -In Progress -Not started*	# Family Physicians engaged (re ated to vers on/ terat on)	CSC *-In place -In Progress -Not started*	Target Population(s) *Name (i.e. frail elderly – home health) & Case definition*	# People in the Target Population *(estimate based on case definition - denominator)*	# Patients receiving new or redesigned services *(cumulative # of unique patients)*	% Reach[2]
1.	Powell River	Powell River	19,733	Testing improve ments	In place	2 in Steering Committee & 21 in various initiatives	In place	Very High & High morbidity (esp. w/ cardio-vascular disease or Mental Health & Substance Use problems)	1,722 + 24 from Connecting Pregnancy = **1,746**	▪ Connecting Pregnancy - 24 ▪ At risk users/ presenters to ED - 60 ▪ Community partnership projects – 117 Total = **201**	201/ 1746 = **12%**
2.	North Shore	North Vancouver & West Vancouver	186,776	Testing improve ments and spread	In place	2 in Steering Committee; & 53 in various initiatives	In place	Chronic, co-morbid/comple x medical care needs	**17,570** (includes 2,200 Home Health clients, 15,220 high needs clients and clients of chronic disease nurses/coordinat or)	▪ GP care conferencing – 122 patients; ▪ Chronic Disease Nurse* in GP practices – 837 in regular caseload ▪ aIPCC projects – 1,431 (ESD-226;AURAA-145; GTN-771**; AHBT-289) Total = **2,390** *Note: The numbers below were not included because the 73 is most likely included in the 837 above and the 3,280 are from the NS Keep*	2,390/ 17,570 = **14%**

**Counted the higher number between GTN In Emergency Assessment and Telephone Follow-up

[1] *Version # indicates progress using incremental improvements; if your HA uses a stages of implementation framework, please indicate that status/iteration)*

[2] *Reach = number of patients receiving services (cumulative count)/ number of patients in target population (actual as per case definition, or estimate)*

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

										Well project who are mobile and active seniors and not likely to be Home Health clients who need assistance in ADL or high needs patients ▪ *Chronic disease nurse coordinator – 73* ▪ *Community partnership projects – 3,280*	
3.	Richmond	Richmond	189,027	Testing improvements & Spread	In place	17 in Steering Committee and working groups; 130 in the pilot or spread of various initiatives	In place	Frail elderly: age 80+ and 70-79 with Alzheimer/ dementia	7,178 (age 80 & over) + 10,592 (age 70-79) = **17,770** *Note: Age 70-79 was added because GTNs target age 70 & over*	▪ GP Care conferencing – 59 patients ▪ Medication Card – 80 patients during trial phase; ▪ Chronic Disease Nurses* in GP practices - 372 in regular caseload; 9 patients seen in CD Management Clinic ▪ aIPCC – 6,106 (ESD-149; AURAA-113; GTN-3,198**; AHBT-173) Total = **4,144** *Note: The numbers below were not included because of possible double count with abovelisted projects* ▪ Screening-Tracking Tool – 30 (20 testing + 10 spread) ▪ Seniors resource List -	4,144/ 17,770 = **23%**

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 2) –March 16, 2013 to June 15, 2013

										278	
4.	Howe Sound	Pemberton Squamish Whistler	33,458; Pemberton on y=5,118	Planning	In prog-ress	2 in Pemberton IPCC Committee	In progress in Pembert on	Population in Mt. Currie Reserve and Southern Stl'atl'inx	**1,800**	▪ Chronic Disease Nurse in GP practices – 40 from First Nations communities ▪ Community partnerships – 66 Total = **106**	66/ 1,800 = **6%**
5.	Vancouver - Downtown Eastside (DTES)	Downtown Eastside Core	61,242	Testing improve ments	In place	8 in IPCC Steering Committee and Working Group; 24 involved in the care of 89 patients	In place	Complex marginalized population	89 High ED users of St. Paul's Hospital – visited 10+ during the year; 700 people living in 8 SROs Total = **789**	• Integrated care process - 45 patients • Primary outreach services teams in 8 Single Room Occupancy hotels (started under IHN) - 700 patients Total = **745**	745/ 789 = **94%**
6.	Vancouver	All LHAs except DTES	568,663	Spread	In place	282 GPs of moderate to high risk patients	In place		Complex patients *Note: Although no formal IPCC table, the target population of initiatives is the complex population, an indicator of which is the RUB score. RUB 4-5 =* ***46,216***	• Chronic Disease Nurses in GP practices* - 332 in regular caseload • Ideal Transition Home – 3,935 patients • aIPCC – 16,645 (ESD-220+292 from PHC; AURAA-107;GTN**-11,704 + 1,875 SPH and 1,734 MSJ; AHBT-641+179 PHC) Total = **20,912**	20,912 /46,21 6 = **45%**
7.	Sunshine Coast	Sunshine Coast	28,936		In place		In progress				

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

8.	Bella Coola Valley and Central Coast	Bella Coola Valley & Central Coast	4,290								

* Chronic Disease Nurses in GP practices under the IHN model will be combined with IPCC in the care model that the community decides.

SUMMARY

		Target Population	Patients receiving services	% of target population receiving new services
VCH	Powell River	1,746	201	12%
	North Shore	17,570	2,390	14%
	Richmond	17,770	4,144	23%
	Pemberton	1,800	106	6%
	Van. DTES	789	745	94%
	Vancouver	46,216	20,912	45%
VCH		85,891	28,498	33%

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 3)

	Community Based Service Delivery Areas **2011/2012**	Collaborative Services Committee priority issues/ <List-may coincide with CSC agendas or IHN Steering Committee Agenda> Below are VCH Local IPCC Steering Committee agenda/issues:	Describe planned new or redesigned services (and % implemented) < describe **key integration** activities that are being prototyped; **include numbers of other providers** such as case managers, nurse practitioners etc >	Patients as Partners Specific examples of how this service delivery element is being embedded by CBSDA i.e. Patient/community partner on CSC; training etc	Care Planning - Coordinated / Shared Care Plans (key elements or, operational definition ; # shared care plans per GPSC billing fee)
1.	Powell River	▪ Sharing of information between GPs and VCH home health & mental health teams ▪ Shortage of Physicians ▪ Timely communication ▪ Shared care plan – eventually electronic ▪ Building community partnerships	▪ Intake Liaison redesign ▪ Home health service redesign ▪ Connecting pregnancy (Interdisciplinary primary maternity care group visits) ▪ "At-risk" users/presenters to ED ▪ Health Resource Navigator ▪ Community partnerships	▪ Patient representation in IPCC planning such as regional and local IPCC steering committees or working group ▪ Formal orientation of patient representatives before involvement in steering committees/working group ▪ Various ways of capturing patient voice such as patient survey, focus groups and patient journey mapping in improvement initiatives ▪ Involvement in care conferencing and shared care planning	Care planning is done as part of case conferencing between GP and community care providers e.g. case manager, home care nurse. Possible measure is: ▪ Patients in the target population who have a care plan in VCH's PARIS (Primary Access Regional Information System) or paper-based tracking system e.g. in integrated care for high ED users/complex patients in DTES
2.	North Shore	▪ North Shore IPCC Steering Committee had a strategic planning meeting in April 2013 to discuss priorities to be focused on in the upcoming year. The priorities include, Home Health Redesign, High Needs Clinic, First Nations Health, GP/Primary Care	▪ GP care conferencing ▪ Home and Community Care intake redesign ▪ Chronic Disease Nurse Coordinator Program ▪ Smart phone app on programs and services ▪ High Needs Clinic ▪ First Nations initiatives ▪ Community partnerships	Same as above	Same as above

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

		engagement, Public Support/Community engagement			
3.	Richmond	▪ Proactive frailty assessment of all people age 80+ ▪ Improved communication and interaction of among team of care providers	▪ Standard referral form for all home health services and LTC 1 assessment report to GPs ▪ Screening-Tracking Tool for the frail elderly ▪ Medication management ▪ Senior's Community Resource List and Key Community Agency Partnerships ▪ Chronic Disease Management Clinic ▪ GP care conferencing ▪ Early Supported Discharge ▪ bestPATH ▪ Community partnerships	Same as above	Same as above
4.	Howe Sound - Pemberton	▪ Building on integration practices in current system ▪ Integration between services at Pemberton Health Centre and Mount Currie and Southern Stl'atl'inx Health Centres	▪ Telehealth ▪ Transportation services inventory ▪ Tool to educate staff discharging patients to Pemberton and surrounding areas ▪ Cultural day ▪ Community partnership	Same as above	Same as above
5.	Vancouver - Downtown Eastside (DTES) Core	▪ Downtown Eastside Second Generation Strategy whose vision in integration of care through better coordination of health providers and community agencies	▪ Integrated care process for complex patients ▪ Consultation process to develop the DTEs Second Generation Strategy ▪ Primary Outreach Services ▪ Community partnerships	Same as above	Same as above
6.	Vancouver	▪ Transitions and care coordination to primary and community care providers for patients discharged from acute care	▪ Ideal Transition Home initiative ▪ Care conferencing ▪ Community partnerships	Same as above	% of time transition plan transferred with patient (Mod/high risk)

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

INTEGRATED PRIMARY AND COMMUNITY CARE

QUARTERLY REPORT (Section 1)

Health Authority : Vancouver Coastal Health	Reporting Period: June 16 to Septembr 15, 2013
Compiled by: Venie Dettmers	Submitted to MOH: September 20, 2013

Summary of Major Progress and Key Accomplishments Since Last Report

Macro (across HA):

A. Accelerated Integrated Primary and Community Care Initiative (aIPCC)

In addition to integration projects under the IPCC bilateral agreement, the projects listed below are being implemented with Accelerated IPCC funding. Separate progress reports are submitted to the Ministry. However, an update on Care Management/Home Health Redesign is included below and number of patients served in all aIPCC initiatives are included in Section 2 of this report.

- ***Avoidance of Unnecessary Residential Care and Acute Admissions (AURAA)*** Provides an enhanced home based service to clients who would otherwise be moved to residential care. Care is provided by an interdisciplinary team with the following focus: intensive care management and an enhanced mix of community-based services designed to meet the needs of clients with multiple, complex and interacting chronic diseases and/or social and environmental factors.

- ***Early Supported Discharge*** In collaborative partnership with GPs, an interdisciplinary community reintegration team supports patients with COPD, CHF and stroke through an early discharge from acute care. The team provides short term rehabilitation for up to three months that includes: coordination, education, and provision of self-care management education and support to patients and caregivers to enable them to have knowledge and skills needed to manage their chronic condition.

- ***Frail Seniors Transition*** Expands interdisciplinary teams that address the community transition needs of older adults (70 + years) who present to ED to support prevention of unnecessary acute care admissions, provide seamless transitions to community and primary care resources after an emergency visit, and provide a coordinated approach to manage complex geriatric issues. The teams include geriatric triage/emergency nurses, transitions nurses for follow up support in the community and community-based pharmacists.

- ***Acute Home Based Treatment (AHBT)*** Provides home-based treatment for mental health and addictions clients as an alternative to hospitalization. The AHBT team consists of psychiatrists, clients, families, GPs and nursing staff supported by social workers, counsellors, or rehabilitation professionals as required. This team follows clients and provides intensive short-term treatment for up to 21 days in the clients' home.

- ***Assertive Community Treatment (ACT)*** A client-centered, recovery-oriented mental health service delivery model, the ACT team is mobile and delivers services in community locations to enable clients to continue to live in their community. This service is provided 24 hours a day by a multidisciplinary team, including a GP, with a low client to provider ratio. The expansion of ACT teams is in its early phase.

- ***Care Management/Home Health Redesign*** Aims to redesign VCH Home Health services to align with the provincial care management strategy and integrate teams with primary care in each

community. The components are inter-professional care conferencing between GP and home health team members and telephonic care management.

In Powell River, as the prototype community, future state maps have been developed for the six population groups. Thirty percent (30%) of the total 90+ identified work bundles have been posted after the reviewing group which is comprised of experts from various disciplines have reviewed the Standard Operating Procedures (SOPs). Another 30% are being worked on. Staffing model for Powell River will be presented to staff and related unions in October 2013.

Education session regarding Home Health Redesign for Home Health staff in Vancouver has been completed. Current state mapping is underway in Vancouver, Sea to sky and Sunshine Coast. Patient focus groups are also underway in Vancouver, Schelt and Gibson, Sea to Sky and Sunshine Coast, Pemberton and Whistler. On September 13th, a presentation was made to Interdivisional Collaborative Services Committee and on Sept 17th an education planning day (phase one) will be held to discuss Education strategy and Education roll-out plan with all stakeholders.

Evaluation Plan has been drafted and is under review by key stakeholders.

B. Other Region-wide Integration Initiatives

- ***First Nations/Aboriginal Initiative –*** The goal is to facilitate the integration of the First Nations and Aboriginal services with the IPCC work. A Regional working group meets regularly and consists of members of the Regional IPCC Team, VCH Aboriginal Team, First Nations Health Authority and the VCH-IPCC Aboriginal/First Nations advisory team which facilitates engagement with First Nations and community members to develop local vision and priorities for IPCC. Highlights during the reporting period were:
  - The inventory/map and analysis of "Availability and Levels of Access to Primary Health Care Services in the 14 First Nations Communities (on-reserve)" was disseminated to concerned parties internally and externally.
  - An inventory/map of services used by Aboriginal people off-reserve/urban areas is being finalized.
  - Engagement with First Nations communities was facilitated for the following VCH initiatives: My Health My Community which is a survey of community health resources; Nurse Practitioner for BC which creates this position in the community; development of a method to identify First Nations/Aboriginal client when using VCH services, and transition of services from United Church to VCH in the Central Coast.
  - First Nations Health Directors from Sliammon, Mt Currie & Southern Stlìtlìmx Health Society, and Squamish & Tsleil-Waututh First Nations are members of local community IPCC steering committees in Powell River, Pemberton and the North Shore, respectively. Joint IPCC initiatives are described in this report under each community.
  - Results of reflections/survey on First Nations/Aboriginal Initiative progress are being finalized.

- ***Regional Intensive Complex Patient Care Planning (RICP2) Initiative –*** The goal is to create a regional care planning process that ensures a comprehensive approach to caring for patients who frequently visit or use the Emergency Department for complex and/or chronic care

management issues. The focus is on those who visited more than 1 urban ED site 20+ times during the year, and are referred to as "Familiar Faces".

- Starting May 1, 2013, a PDSA trial phase for developing and initiating an integrated community based approach to care planning began.
- A Shared Care Plan Tool was created through the work of a subcommittee represented by many disciplines. This tool is based on the IHI model, and consists of 2 parts - the multidisciplinary clinician care plan, and the patient simplified version entitled "My Health Care Plan".
- To date 12 Familiar Faces have consented to having a shared care plan. All 12 shared care plans are in active development, and it is anticipated that all will meet the targeted timelines.

- ***Updating of the VCH Integration and Performance Measurement Framework*** The goal is to update the overarching VCH integration framework to describe the desired future integrated care system and the progression/roadmap to get there based on best practices and the VCH IPCC experience to date. A regional performance measurement and evaluation plan is being developed.
- ***Regional Steering Committee Survey*** : The goal was to capture perceptions of IPCC progress, how the Steering committees are functioning and recommendations needed to move forward. The on-line survey was administered in June with analysis and report being finalized for October distribution.

Meso and Micro (for specific populations or patient groups; by CBSDA):

1. Powell River

- Powell River IPCC Steering Committee Further leadership changes to occur with the hiring of the new Director for VCH Powell River effective September 2013. Steering committee is co-chaired in partnership with Director for VCH PR and Physician Lead for Divisions of Family Practice. New Health Director for Tla'amin nation, Cynthia Jamieson, has joined the steering committee.

- Physician Engagement Strategy Working in collaboration with the local Divisions of Family Practice to continue to engage physicians in the redesign work.

- The following improvement projects are being implemented to achieve integration of care:

1. **Intake Liaison Redesign Integration Initiative** The objective is to develop a more streamlined and efficient referral process from primary care to Home and Community Care (HCC). ***Stage of Project: Spread Phase:*** With the collaboration of the Practice Support Program (PSP), Physician Information Technology Office (PITO) and VCH, a new system of referral from Primary Care to Home and Community Care that mimics e-referrals from Electronic Medical Record (EMR) has been implemented. Family physicians are now notified of receipt of referral and services in place for patient. Data is being tracked for 3 months post implementation to ensure compliance with the new process. A total of 35 referrals from July 3 Sep 9, 2013 have been received from family physicians for home care services.

2. **Home Health Service Redesign** To better meet the need of clients, changes in practice of Home and Community staff are being implemented as part of the Care Management Strategy.

Stage of Project: ***Testing***. As the prototype community, future state maps for the six populations of home health clients have been developed. The five population groups identified are: Chronic Co-Morbid; End of Life/Palliative; Adult Living with Significant Disability; Post Surgical/Episodic; and Frail/Complex Older Adult/ Dementia.

3. **Connecting Pregnancy Program** The objective is to develop a rural model of interdisciplinary primary maternity care. The program is co-facilitated by a family physician who provides individual prenatal care during the sessions and a public health nurse. Three cohorts have successfully completed the program with a fourth cohort in progress. Evaluation report (2011-2012) has been completed ***Stage of Project: Spread***. Next step is to engage remaining five obstetric physicians in the community to partner with the rural model of interdisciplinary primary maternity care. Evening session is being planned to present the model and discuss possible partnership.

4. **"At Risk" Users/Presenters to the ED** The objective is to better respond to "at-risk" or "high use" patients whose care can be improved by better coordination through the Powell River Hospital Emergency Department. The focus is on the following areas:

   - **Mental Health (MH) or Addictions Crisis:** PR hospital ED was seeing an increase in patients using ED as source of primary care, resulting in an increase of inappropriate referrals/admissions to psychiatry from ED. There was a need to establish better processes to improve communication between the departments, foster stronger relationships, and enhance interactions between providers to provide better patient care. A new algorithm of standard practice has been implemented is being applied in the ED for patients presenting with Mental Health or Addictions concerns. In-patient psych nurse collects electronic health records on known patients (discharge/psychiatry summary, careplan) then visits the patient in ED, conducts a MH assessment, and consults with the ED physician. This detailed MH assessment and information enables the ED physicians to better assess & triage the patient and create a partnership between MH & ED in patient care. A discharge summary is also sent to the GP, completing the circle. Since Dec 15-2012 a total of 228 ED assessments have been conducted. In Aug 2013 alone, 37 assessments were completed. . Patients report that they feel heard, all MH patients are seen now (proactive), ED staff finds value in the in-depth assessments, and inappropriate admissions to psychiatry are avoided. It has opened a line of communication between MH and ED staff, and GPs.
     Stage of Project: Standard Practice.

   - **Chronic Pain:** Current practices of treating patients with chronic as well as acute chronic pain episodes in the ED are being reviewed. ***Stage of Project: Planning***. A physician has been engaged into discussion as a referral pilot to treat patients with chronic pain. Further investigation regarding TeleHealth options connecting with regional chronic pain supportive options are being followed up. Further analysis of patients presenting is underway.

   - **Acute Pain:** A change in practice for providing more appropriate first-time pain control to patients presenting with acute pain is being assessed/reviewed. ***Stage of Project*: *On Hold***. Discussions regarding RNIA (Registered Nurse Initiated Action) are ongoing. Powell River is potentially a pilot site for RNIA narcotic administration to improve pain control

for patients in ED.

- **Rapid Process Improvement for Patients with No Family Doctor** ***Stage of Project*****:** ***Spread.*** A workshop was held in March to reduce the number of ED visits by patient with no family doctor (NFD) and ensure that comprehensive care is provided to patients right care for the right patient in the right place at the right time. There were 27 improvement ideas identified of which nine have been completed. Patients with NFD are being flagged at admission. Upon discharge, NFD's are encouraged to use the Primary Health Care Clinic in Ambulatory Care that operates once a week for five hours. Work in progress includes flagging patients at admission who are known to Home Health and Mental Health, introducing discharge summary and care plan form to ED staff to PDSA, educate ED staff on community referrals and resources, educate ED staff on Home Health referral and general information on Home Health services, option to access Home Health staff or care plan for known patients who present to the ED, initiate rapid access with Home Health, NFD patients leaving ED with a primary care provider.

5. **Health Resource Navigator –** The objective is to assist physicians in identifying available health and social support services and linking patients to these services. The Resource Navigator will be responsible for sourcing available community, regional, and provincial health and social support services and will determine the best method of keeping up-to-date listings of these services and the best methods of communicating this information to physicians. The navigator will support physicians in linking patients to the most appropriate service. ***Stage of Project: Testing***. Resource Navigator has been hired effective May 15, and has started to meet with community programs and physicians. Evaluation plan has been developed. A total of 14 requests have been received from family physicians regarding available services in the community. Evaluation is on-going.

6. **Integrated Practice Support Initiative (IPSI) Powell River Initiative** The objective is to strengthen the delivery of quality practice support by aligning PSP and PITO practice support services. This local initiative is lead by the Division of Family Practice (DoFP) and the IPCC evaluator has been invited to provide evaluation work and the Powell River Change Lead has been asked to join the IPSI Committee. Evaluation activity is on-going and will culminate in a final evaluation in the fall of 2013.

7. **Shared Care Initiatives** The objective is to ensure that primary care is delivered and managed by family physicians with ready access to specialist physician advice and support. The focus in Powell River is palliative care. ***Stage of project: Planning.*** Current state is being assessed and stakeholders engaged in order to identity gaps and move forward with a full shared care proposal.

8. **Community partnership** projects funded in 2013/14 and their status based on Q1/April-June report are the following:

   - ***Building Recovery of Individual Dreams & Goals through Education (BRIDGES) (BC Schizophrenia Society):***
     Purpose of the program*:* help people understand and recover from mental illness. A course taught by consumers for consumers to empower people with tools that will help them in their journey to recovery. Meetings are held the third Monday of each month

from 7:00 to 8:30 pm, in the meeting room on the third floor of the hospital.

- Total of 40 clients served since start of VCH funding. Average of 20 clients per month accessing the program
- Age range of clients: 46 55 years old
- Gender: 16 male and 24 female
- Health issues: diabetes, chronic pain, depressions, asthma, arthritis, substance abuse
- Social issues: social isolation, financial challenges, housing, family alienation

Key Successes:

- has provided clients with motivation to take other courses
- has helped overcome social isolation
- give people purpose and helps them establish a routine rather than feeling there is no reason to get up in the morning.

- ***Powell River Employment Program Society*** provides two programs to the community for:
  - Clients with health issues: diabetes, chronic pain, depression, asthma, arthritis, heart disease, addictions, HIV and other communicable disease, and mental health;
  - Social issues: social isolation, financial challenges, housing, and food security

  - ***Humble & Hearty Workshop***

    Purpose of the program: Deliver 18 participatory workshops annually to show low-income clients with chronic health conditions how to cook healthy meals using low-cost ingredients.
    - Total of 333 clients served since start of VCH funding. Average of 19 clients per month accessing the program.
    - Q1 referrals: Total of referrals 54 of which 48 were self referrals
    - Gender: Male 50% Female: 50%
    - Age range of clients: 26 65 years old
    - 7 workshops offered; 20 people participated of which 17 have attended more than one workshop.

    Key Successes:
    - Relationship building, good friendships and mentoring.
    - Clients are excited about each workshop and most claim to have used the recipes at home
    - Clients have changed their eating habits and lost weight

  - ***Monday Brunch***

    Purpose of the program: Increase access to meals for people with chronic health problems and increase access to public health professionals and other educational and social supports.
    - Total of 2047 clients served since start of VCH funding. Average of 155 clients per month accessing the program.
    - Gender: Male 60% Female 40%
    - Age range of clients: 16 - 65 years old

      "They like the food that is served as they can't afford to cook these kind of meals at home and the food bank does not provide fresh food".

"It really helps towards the end of the month before I receive my cheque"

Key Successes:

- Made a difference in eating habits of people's lives
- Patrons ask for healthier food items to be served
- Opportunity to discuss patrons health challenges
- The centre has delivered 3 series of the 'Chronic Pain Self Management' workshops coordinated by the UVIC Centre of Aging. One workshop was delivered during the Monday Brunch period. A total of 18 participants have completed the 6 week, 2.5 hour program. One participant has quit smoking as a result of taking this program.

Number of brunches offered during the quarter: 12 with an average of 37-55 participants. A public health nurse was in attendance during the brunch three times and social support is always available from staff and peer support.

- ***Promoting Community Wellness (The Source Club Society)***

  Purpose of the program: Promoting community wellness and providing people living with mental illness with social and recreational activities, opportunities to engage in health practice.

  - Total of 368 participants since start of VCH funding.
  - Gender: Male 10% Female: 90%
  - Age range: 26 65 years old
  - Health issues: depression and arthritis
  - Social issues: social isolation, financial, and food security
  - The Yoga Program continues to support the participants' needs for mental and physical fitness. Focus has been on strength, flexibility, balance and relaxation.

  Key Successes:

  - Clients report less pain and feeling of well being
  - Has made a great difference in patient's mental health as well as the physical health.
  - People are engaged and return regularly to the sessions

2. North Shore

- Key activities related to the North Shore IPCC Steering Committee:
  - All North Shore strategic priorities are standing items discussed at each meeting. Strategic priorities include Home Health Redesign, Aboriginal Health, GP and community engagement, and the High Needs Clinic.
  - The Committee aims to have at least one guest speaker present at each meeting.
  - Steering Committee's Terms of Reference will be reviewed to ensure the membership reflects the current purpose of the group.
  - First Nations Working Group (North Shore/Coastal) The purpose of this working group is to improve linkages and communication among First Nations Health Centres, Lions Gate Hospital, Primary Care and Mental Health & Addictions.

- The following improvements are being implemented to achieve integration of care:

1. **GP Care Conferencing** Care conferencing in person or over the phone between Home and Community Care (HCC) staff was rolled out beginning of October 2012. This rollout builds on the pilot testing of care conferencing with case managers in late winter/spring 2012. ***Stage of Projec***t: ***Spread***. Process has been rolled out to all HCC clinicians. Workflow has been established and clerical support implemented to arrange conferences for clinicians. To date, 155 clients have had care conferences conducted on their case. In total 73 GPs have engaged in care conferencing with 44 HCC staff.

2. **Home and Community Care Intake Redesign** In response to a Lean analysis recommendation, an intake clerk position was created to reduce the amount of non-clinical administrative work such as faxing, collecting demographic information by intake nurses, and having 'live' clerical support answering calls. ***Stage of Project: Sustainment***. As of December 2012, a new workflow has been established in order to reduce the bottleneck of referrals and increase feedback and communication to GPs on the status of the referral to Home & Community Care.

3. **Chronic Disease Nurse Coordinator Program** The objective is to engage family physicians to refer their patients with two or more chronic conditions for comprehensive guideline-based care to the Chronic Disease Nurse Coordinator who will support and help manage their chronic conditions. A key change idea for this program is that the CDN Coordinator is housed in a central location at a Community Health Centre rather than embedded in a Family Physician's private practice ***Stage of Project: Sustainment***. At the end of August, a total of 98 clients from 29 different GPs were referred with 68 active clients (and 30 clients discharged from the program). Additional presentations to GPs and other VCH programs are planned to continue to build program awareness and increase the number of referrals.

4. **Smart Phone App** The objective is to make information about programs and services that support the health and wellness of the North Shore population accessible to physicians and their MOAs. A directory of physicians indicating their specialty has been incorporated into the App and its web-based version (the latter intended for those without a smartphone). ***Stage of Project: Deployment pending.*** Practitioner data has been entered and coding has been refreshed for the mobile App and website/server side. App developers are waiting for go-ahead to deploy to the App Store and to a third party host server. A third party server provider has been identified and the VCH Legal Team is currently reviewing the service agreement. Consultation with VCH Information Privacy Office has also been completed.

5. **High Needs Clinic** The objective is to establish an integrated primary care clinic that will provide health care services to vulnerable North Shore residents with complex medical, mental health and/or socio-economic challenges and have no GP or a loose attachment to a GP. This clinic is a partnership between North Shore Division of Family Practice and VCH. ***Stage of Project: Implementation***. The Steering Committee and various sub-committees continue to meet to refine processes, workflows and clinic forms. A robust evaluation plan has been developed in order to assess how well clinic aims to reduce health care utilization, improve health outcomes, and improve the client experience are being met. From July 2 to Sept 5, 2013 inclusive, a total of 152 visits to the clinic were made. Of these, 56 were new client visits. An average of 3.3 visits per day (9AM to 12PM, Monday-Friday) is made to the clinic. A Clinic Open

House for VCH staff, community service providers, local politicians and media to learn more about the clinic is scheduled to take place on September 30. A robust developmental evaluation is occurring .

6. **Integrated Practice Support Initiative (IPSI) North Shore Initiative** The objective is to strengthen the delivery of quality practice support by aligning PSP and PITO practice support services. The lead evaluator from the IPCC Regional team has been asked to be involved with the local IPSI initiative that is lead by the DoFP. Evaluation activity is on-going and will culminate in a final evaluation in the fall of 2013.

7. **Shared Care Initiatives** The objective is to ensure that primary care is delivered and managed by family physicians with ready access to specialist physician advice and support. Areas of focus in the North Shore are orthopaedics, mental health and oncology.
   Orthopaedics ***Stage of project: Testing and scaling up*** for the following projects: advice line, centralized referral system, screening clinic, referral acknowledgment and consult template and sharing of care. And ***Planning stage*** for accurate identification of family physician upon acute admission.
   Mental health ***Stage of project: Testing and scaling up*** for one time consult followed by group visits. And ***Innovation development*** for transitions into and out of acute and referral processes to psychiatry.
   Oncology ***Stage of project: Innovation development*** for rapid access to breast cancer care and specialized role of a family physician in oncology.

8. **Community partnership** projects funded in 2013/14 and their status in Q1 (April-June) are the following:
   - ***Counseling Service for Patients with Complex Health Issues*** - individual and group counseling for individuals experiencing mild to moderate depression and chronic illness. Number of referrals received: 21; Patients seen during the quarter: 14.
   - ***Peer Support for Health and Wellness*** - offers one-on-one emotional support, guidance regarding life changes and challenges, as well as provide resource information. Number of intakes from community: 15 who were provided 100 support hours.
   - ***North Shore Keep Well*** - an exercise and wellness program for mobile seniors to encourage and help older adults to keep well by leading active and independent lives. The program includes one hour of exercise followed by blood pressure checks and health coaching, massage, speakers and social times. Total attendees during the quarter in 7 sites: 3,434.
   - ***Golden Circle*** offers wellness and leisure education to frail seniors who may have challenges accessing programs. It includes out-trips, healthy snacks/social time, education speakers, brain and memory games, chair exercises and other recreational activities. Total number of participants for the quarter: 344
   - ***First Link*** a first response strategy for people newly diagnosed with dementia and their families. It includes proactive outreach, information and connections, and planned follow-up. In order to ensure that services appropriate to people with early symptoms of dementia are available in the community, Minds in Motion™ and Shaping the Journey: living with dementia™ are implemented alongside First Link®.
     Status in the North Shore and Sunshine Coast is as follows:
     - Number of Shaping the Journey participants 11

- Number of Minds in Motion Participants 39

- ***Volunteer Drivers –*** Run by North Shore Neighbourhood House, the medical rides pilot project uses NSNH trained peer support volunteers who donate their time and personal vehicle to transport and accompany complex clients to and from their medical appointments and treatments. This service is structured similarly to Capilano Community Services Society medical rides program, but draws from a different pool of volunteers with senior peer support training. Number of rides: 1 and number of volunteers: 2.

4. Richmond

- Key activities related to the Richmond IPCC Steering Committee:
  - Change in leadership; new director of Primary, Home and Community Care hired at the end of June 2013
  - A one page report was developed and shared at the July/August meetings based on the comprehensive reflection meetings held in April/May. Key highlights include
    - Primary Care Physician to co-chair with VCH Primary, Home and Community Director
    - Reaffirmed that the focus will continue to be on improving services for the frail elderly.
    - Priorities assessed

    A copy of the "Moving Forward Progress Report" which includes key priorities is attached.

    June 2013
    ıg Forward wi

  - RH Acute Care Director is a new member of Richmond IPCC Steering Committee
  - Terms of Reference are in the process of being reviewed in light of new leadership, progress report and addition of new members.

- Continued to strengthen linkage and partnership with DoFP
  - Invitation to participate at the Sept 17th MOA event. Richmond IPCC Lead to share and provide information on 3 integration improvement tools (Screener Tool, Seniors Resource and Support List; and GP Care Conferencing).
  - Submission of brief summaries to the DoFP newsletter re integration initiatives such as the Screener Tool and GP Care Conferencing.

- Continued to work in partnership with PSP to leverage integration work
  - Information re GP Care Conferencing will be shared at the End of Life Module 3rd session. As well, copies of the brochure re the new Chronic Disease Management Clinic will be made available.
  - Richmond IPCC Lead and Richmond staff participated and shared information re Seniors Resource and Support List and GP Care Conferencing at the *Lunch and Learn* MOA event on August 16. (8 MOA attended)
  - Richmond PSP Lead provided assistance regarding the evaluation of the Medication Card initiative to several GP practices who were participating in the trial phase.

- The following improvements are being implemented to achieve integration of care:

QUARTERLY REPORT (Section 1)

1. **Standard Referral Form and Long Term Care 1 (LTC1) Report** The objective is to streamline the referral process from GP to HCC and feedback to GPs. The HCC referral form has been redesigned and a feedback loop confirming services to the GP is part of SOP. A LTC 1 Report will be faxed to GPs regarding new clients referred to Case Management. ***Stage of Project***: ***Spread to all the 130 GPs***. Tracking results indicate referrals forms are being completed appropriately; very little error or misses. An evaluation plan is being developed.

2. **Screening-Tracking Tool for Frail Elderly** This one-page screener was developed with Family Physicians to use in their practice to actively case find frail elderly patients who could benefit from referral to Case Management (CM) service and to proactively identify clients who are not eligible for CM, but are at risk and may benefit from social supports and services available in the community. ***Stage of Project: Spread***. The tracking of the screener tool indicates that as of May 2013, 26 tools were completed by 14 GP Practices.

   A Poster presentation of the screener tool initiative was presented at the Provincial Divisions Round Table by Richmond DoFP in June 2013 as an example of how partnership between a division and the health authority can bring mutual benefits to both partners while enhancing patient care.

   
   Richmond June
   Round Table Poster fi

3. **Medication Management** The objective is to create an accurate patient medication list to improve communication and interaction within the inter-professional team resulting in coordinated care, awareness of patient status and reducing duplication of work and frustration. ***Stage of Project*: *Pilot/Testing.*** The BC Patient Safety and Quality Council medication card is being tested in 13 GP practices. Moreover, Home Care Nurses have been asked to trial the medication card among their patients. **The pilot phase is now completed**. Patients and providers are in the process of being interviewed/surveyed. In addition, the survey data that looked at the list of services provided by Richmond pharmacies to clients are now being compiled. The intent is to create a handout that can be used by primary and community care providers with their patients/clients.

4. **Senior's Community Resource List and Key Community Agency Partnerships** The objective is to develop one resource list for GPs and other health care providers to use in their practice that includes non medical supports and services available in Richmond for seniors. A trial phase was conducted and evaluation completed. An evaluation newsletter was developed and the results were shared at the IPCC steering committee. For more detailed information, refer to attached newsletter.

   
   Senior's Resource
   and Support List Evali

   Stage of Project: Spread. This resource folder was showcased at the AGM. 22 GPs who attended the AGM signed up to receive a copy of the folder. The working committee is in the process of making the final changes; it was decided by the members to work and complete a section on

Mental Health (based on the feedback from the participants during the trial phase). The new target date for the resource to be completed is September/October 2013. The resource list will also be made available for download on the VCH Primary Care website which will be launched in September. The resource list will be updated annually.

5. **Chronic Disease Management Clinic** A Chronic Disease Management clinic was established at 8100 Granville with the objective to engage GPs in referring patients with chronic conditions for comprehensive guideline-based care to a centrally located clinic. Chronic Disease (CD) Nurses (2 of the 5 nurses are able to speak Chinese) will support patients to manage their health conditions. A key change is that CD Nurses can provide support to GPs who DO NOT have a nurse attached to their practices. ***Stage of Project***: ***Pilot***. To date 18 Family Physicians Practices have been approached. This includes 9 GP Practices who have a predominately large Chinese speaking population. As of August 2013, 38 patients have been seen. The brochure, describing the services of the CD Clinic has also been translated in Chinese.

6. **GP Care Conferencing –** GP Care conferencing initiative was launched in February 2013. They are scheduled in advance with the GP, thereby ensuring that all participants in the conference have dedicated time to focus on the patient's needs. A working group with GPs and Home Health staff has been formed to work on process steps, to address issues as they come up and to determine how to share and communicate information regarding care conferencing to Richmond GP Practices. ***Stage of Project***: ***Spread***. To date, 105 clients have had care conferences held on their case.

7. **Early Supported Discharge -** The objectives are to support early discharge of clients with chronic conditions from acute care; support and improve patient self-management of chronic conditions. ***Stage of Project***: ***Spread.*** An interprofessional working group has been established to lead and facilitate family physician and patient/family input regarding the process and delivery of the program as well as to carry you a robust evaluation. A GP focus group (5 GPs participated) was conducted in June. Key themes included simplifying the notification forms, provide BRIEF updates and involve GPs two weeks prior to patient discharge from the program. As a result, ESD team is working to improve the forms currently used, reassess information given to GPs re updates/consult notes and implement a protocol that includes setting up a care conference with GP to discuss the patient's health status prior to being discharged from ESD. The results of the patient survey were evaluated and presented; a newsletter was developed to highlight the key results. Refer to attachment below for more detailed information. There is strong interest and commitment to look at carrying out a patient focus group to gather information regarding the patient experience and delivery of the program in the late Fall.

IPCC Evaluation Newsletter #4 - Richr

8. **bestPath –** (Person-centred, Appropriate, Timely Healthcare) has recently been launched by VCH-Richmond. bestPATH is a partnership between Richmond acute teams, community teams and primary care to improve health outcomes; improve the care experience for our patients and clients; and improve workflows and the experience for care providers. ***Stage of Project***: ***Spread.*** The bestPATH strategy will roll out in phases starting with the 3 South acute unit team and South community team. Phase I will involve developing a better understanding of the current

environment and identify opportunities for improvement with input from all care providers, patients/clients and families. Phase II will see the Steering Committee and Working Groups implement the solutions that have been identified.

The focus of IPCC is ensuring the primary care lens is included. Family Physicians were invited to participate in 5 workshops that were held in May, June and July to provide input from a GP perspective regarding the current process as the patient journeys from Acute to Community and Primary care. Six Family Physicians participated. The maps that were completed during these sessions and were also validated by Richmond IPCC GPs at the June 21st. Two hospitalists have been engaged to participate and provide input as well however did not participate in the workshops. In addition, one of the Family Physicians participated in a job shadowing activity in home health to learn about the role of the Home Care provider as it relates to patient care and to gain a better understanding regarding the philosophy and approach that is embedded in Community Health Services.

9. **Shared Care Initiatives** The objective is to ensure that primary care is delivered and managed by family physicians with ready access to specialist physician advice and support. Areas of focus in Richmond are orthopaedics and rheumatology. ***Stage of project: Innovation development*** for referral processes.

10. **Community partnership** projects supported in 2013/14 and their status in Q1 (April-June) are the following:
    - ***Wellness Connections Program*** - a transitional therapeutic recreation bridging program that enables frail isolated seniors and people with multiple chronic conditions to identify and master the skills for community recreation participation and community inclusion.
    - ***First Link*** a first response strategy for people newly diagnosed with dementia and their families. It includes proactive outreach, information and connections, and planned follow-up. In order to ensure that services appropriate to people with early symptoms of dementia are available in the community, Minds in Motion™ and Shaping the Journey: living with dementia™ are implemented alongside First Link®. Status in Richmond/South Delta is as follows:
        - Number of referrals received during the quarter - 54 with majority coming from assessment clinic/specialist.
        - Number of active cases to date 482
        - Number of Shaping the Journey participants 8
        - Number of Getting to Know Dementia participants 10
        - Number of Minds in Motion participants 33
        - Outreach to health professionals/Number of meetings and presentations) - 3

4. Pemberton and Squamish in Sea-to-Sky

- The Pemberton IPCC Committee continued to provide support and direction to the identified opportunities for improvement:
  - Continued working with First Nation in Mt. Currie to find opportunities to improve integration of services with VCH.
  - **Telehealth** The objective is to improve communication between healthcare providers and clients living in rural communities. E20 units have been installed in communities and have been used 20 times in Pemberton to coordinate patient care. ***Stage of Project: Pilot***

- **Transportation services** The inventory has been completed. It includes a list of what transportation is available within the community and the services available to Vancouver. Also developed was an inventory of funding sources available to access transportation needs. Next step is to align with the Better at Home work.
- ***Discharge Information form*** The objective is to better support hospital discharges to Pemberton. The form contains information about discharging a patient home to a rural community. Rural communities have specific challenges with transportation, available services and access to specialized medication and equipment. ***Stage of project: Spread***. The form is being used with local hospital staff.
- ***Nurse Practitioners*** are being hired.
- **Shared Care Initiatives** The objective is to ensure that primary care is delivered and managed by family physicians with ready access to specialist physician advice and support. Area of focus in Squamish is oncology. ***Stage of project: Innovation development*** for improved processes for the delivery of chemotherapy within the community; and improved communication and continuity of care between the Squamish physicians and Lions Gate Hospital.

- **Community partnership** project supported in 2013/14 and their status in Q1 (April-June) are the following:
  - ***Bowling for Life*** an opportunity for seniors of Pemberton and elders in Mt. Currie to come together for an afternoon of Wii bowling and lunch. Average number of participants: 66
  - ***Exercise 4 Brain & Neuro Health in Squamish*** - Program will be launched in September. Program is full at 8 participants, 2 on the wait list. The aim is to provide exercise and support to patients with neurological conditions such as MS, Parkinson, stroke.

5. Downtown Eastside (DTES) Vancouver

- **Integrated care process for the high ED users –** The objective is to improve care coordination and proactive community-based care planning. The study cohort consisted of 89 clients who visited St. Paul's Hospital ED 10 or more times between April 1, 2011 to February 2012. Five community sites and St. Paul's Hospital ED participated. The integrated care process was piloted from July 2012 to June 2013 and included the following elements: registry, review of client file, identifying primary care lead, reviewing ED care plan, identifying other clinicians, meeting with client, case conferencing with client, developing a care plan, sharing the care plan and care plan follow-up. ***Stage of Project: Sustainment***. The pilot period ended in June with 45 clients receiving some elements of the integrated care process of which 26 have a documented shared care plan. Best practices are being incorporated into everyday work and complex clients will be the target client group. A Best Practice Guidance was developed to document best practices, challenges and lessons learned arising from the pilot project see insert below. Final evaluation activities are ongoing including interviews and survey of providers as well as analysis of health utilization indicators. A final evaluation report will be completed by November 2013.

Guidance Document DTES IPC(

- **Primary Outreach Services Teams** The goal is to provide primary care on site for people who have difficulty accessing care. Teams continued to hold clinics in single occupancy hotels (SROs) and shelters providing mental health, addiction and primary care. They also provide ongoing case

management and health care support to 700 clients. ***Stage of Project: Standard Practice.***

- **Community partnerships** Continue to be supported in SROs to provide tenancy supports through the non-profit organization operating the SRO including: Raincity Housing and Support Society, and Portland Hotel Society Community Services.

6. Vancouver

Vancouver Community of Care has initiated projects that facilitate integration of care. They include:

- **Ideal Transition Home (ITH)** The goal is to improve the patient and family experience and provide quality outcomes for patients discharged from VGH and Providence. The interventions are:

  Within 48 hours of admission:

  - *Readmission Risk assessment* score initiated (early identification of patients at moderate to high risk for readmission)
  - *Readmission Risk mitigation checklist* initiated (standardized interventions)
  - *Hospitalization notice* faxed to GP in community
  - *Referral* sent to community for known clients and for assessment for new clients

  And upon discharge:

  - *My Discharge Plan is* completed and given to patient/family and faxed to community and community GP (discharge notification fax).
  - *High risk patients* - Follow up GP appointment made prior to discharge for 48 hours post discharge.
  - *Moderate risk patients* Follow up GP appointment made prior to discharge for 3-5 days post discharge and a follow up phone call to patient/family by Care Management Leader 48 hrs post discharge.

  Stage of Project at VGH: Spread phase. The estimated number of patients that have been discharged through the ITH process since the implementation in February 2012 to end of August was 4,663 of which: High Risk = 1,884 and Moderate Risk = 2,779.

  Stage of Project at Providence: Testing/prototype development of the frontend elements of the ideal transition home care process.

- **Care Conferencing –** The objective is to better coordinate care between GP and home health staff. ***Stage of Project: Spread.*** To date, 145 clients had a care conference held on their case.

- **Home Health Redesign** - To better meet the need of clients, changes in practice of Home and Community staff are being implemented as part of the Care Management Strategy. ***Stage of Project***: Planning. Current state mapping of home health programs and patient focus groups are underway.

- **Shared Care Initiatives** The objective is to ensure that primary care is delivered and managed by family physicians with ready access to specialist physician advice and support. Area of focus in Vancouver is internal medicine. ***Stage of Project: Innovation development*** for improved communication with family physicians upon patient's admission; invitation to family physician to take part in the patient's care while they are admitted; and improved involvement with the family physician in the creation of the care plan; notification of discharge to the family physician; and appointment with the family physician within 72 hours of discharge.

- **Community partnerships** supported in 2013/14 and their status in the previous quarter (April-June 2013) are as follows:

- ***Development of COPD-related Educational Materials with an Appropriate Assessment of Health Literacy and Ethnic Needs (BC Lung Association*) –** The objective is develop, based on inputs from patients and front line health workers, educational materials in English, Mandarin, Cantonese, Farsi, Korean and Filipino to address specific issues such as: Mode of action of medications; How to use different inhaler devices; The role of action plans in COPD; The importance of pulmonary rehabilitation and the key components that a patient may expect to learn; and A patient information sheet to be provided to patients after they have had a COPD exacerbation either after a hospitalization or visit to the Emergency or an exacerbation managed by their primary care physician in the community.

  All six documents for educational materials have been translated into Korean, Farsi, Tagalog, Chinese. Focus groups have been conducted to review the translated educational materials: 1 Korean, 2 Filipino, 3, and 1 Cantonese. One script was developed in English for the inhaler video and has been translated into all the community languages for production. Different venues were explored to recruit patients.

- **Strengthening Community-based Resources for Families Experiencing Perinatal Depression and Anxiety and Their Health Care Providers (Pacific Post Partum Support Society (PPPSS)) –** Information gathered and recordings from patients and healthcare professionals and community support workers will be used to: a) Streamline existing distribution mechanisms for PPPSS resource materials. b) Create new culturally appropriate content for the Chinese, Farsi, Punjabi, and Spanish language informational brochures (Farsi and Spanish brochures do not currently exist). c) Update PPPSS training materials for community-based health care professionals, including the use of video interview segments designed to reduce stigma. d) Make the PPPSS website more engaging, interactive, and culturally appropriate, including the use of video interview segments designed to reduce stigma.

  All planned patient focus groups and video interviews have been completed. Website redesign also completed and new site launched in August. Primary care physician interviews are ongoing.

- **Access For All – Supported Health & Wellness Program (Langara Family YMCA) –** The objective is to provide VCH clients with opportunities and support to improve physical activity and develop exercise habits and healthy lifestyle behaviours. The priority target groups will be clients deemed as high risk for exercise cessation. This project builds off of the current and successful Access For All model while incorporating a consistent, detailed and thorough support and follow-up component.

  Information dissemination to and orientation of VCH clinicians have started with a meeting of YMCA staff and the Healthy Living Program team which coordinates referrals to Access for All.

- ***First Link (Alzheimer's Society)*** a first response strategy for people newly diagnosed with dementia and their families. It includes proactive outreach, information and

connections, and planned follow-up. In order to ensure that services appropriate to people with early symptoms of dementia are available in the community, Minds in Motion™ and Shaping the Journey: living with dementia™ are implemented alongside First Link®.

- Number of referrals received during the quarter - 69 with majority coming from assessment clinic/specialist.
- Number of active cases to date 162
- Number of Minds in Motion Participants 98
- Number of participants in Caregiver Series (Cantonese only) 70
- Outreach to health professionals/Number of meetings and presentations) - 4

- ***Education Programs for People Living with Arthritis-Expansion in Vancouver (The Arthritis Society BC & Yukon Division)*** **-** The purpose is to help patients to learn to live well with arthritis and for health providers to learn about this disease in order to better understand this chronic disease and how to work more effectively with patients. The Arthritis Society will offer a four part education program that includes Arthritis Self-Management Programs and Chronic Pain Management Workshops plus offer a targeted ten workshop series designed to provide information and support in a small group setting.

  Programs to be launched in September through March. Scheduling is nearly complete. Five new Arthritis Self Management Program leaders were trained in June to offer the programs scheduled to start this fall. Plans are underway for in-service for staff to be held in December. A further training session for the Chronic Pain Management Workshop leaders will be held in the fall.

Key Issues, Dependencies and Mitigation Strategies:

QUARTERLY REPORT (Section 1)

Issues/dependencies/barriers across communities:	Mitigation Strategy:
▪ Home Health Redesign initiative is unfolding and at the fore front.	▪ IPCC team to work closely with Home Health Redesign team to provide the system integration perspective and ensure connection of services with related integration initiatives.
▪ Engagement of physicians and their Medical Office Assistant to create buy-in for integration improvements	▪ Look for opportunities to meet/include MOAs in order to provide information re integration initiatives. Be aware of the challenges they face in their day to day work.
▪ Many Family Physicians have limited understanding re the services provided by Home Health and the roles and responsibilities of community health care providers	▪ Invite Family Physicians to shadow community health care providers in order to gain a better understanding of the philosophy and services provided by Community Health services.
▪ How to ensure best practices/improvements are sustained and become part of everyday practice	▪ Memo from Director regarding transition of project work to everyday work and monitoring of key indicators for a period time

Successes and Lessons Learned:

- Change takes time.
- Leadership is key to the success of an initiative
- Change in leadership may slow down the momentum however there is also opportunity for new ideas, energy, insights and new partnerships.
- Documentation of best practices and lessons learned are useful to inform similar initiatives.

PRESENTATIONS

- Maureen Sexsmith. Integrated Interprofessional Care for High Emergency Department Users in Downtown Eastside. Presentation at the Community Health Nursing Conference on June 17-19, 2013 in Kelowna, BC.

QUARTERLY REPORT (Section 2) – June 16, 2013 to September 15, 2013

	Community Based Service Delivery Areas	Communities included in CBSDA	Total Population of CBSDA	Version #[1] /stage planning & implementation	Division *-In place -In Progress -Not started*	# Family Physicians engaged (re ated to vers on/ terat on)	CSC *-In place -In Progress -Not started*	Target Population(s) *Name (i.e. frail elderly – home health) & Case definition*	# People in the Target Population *(estimate based on case definition - denominator)*	# Patients receiving new or redesigned services *(cumulative # of unique patients)*	% Reach[2]
1.	Powell River	Powell River	19,733	Testing improve ments	In place	2 in Steering Committee & 21 in various initiatives	In place	Very High & High morbidity (esp. w/ cardio-vascular disease or Mental Health & Substance Use problems)	1,722 + 30 from Connecting Pregnancy = **1,752**	▪ Connecting Pregnancy - 30 ▪ Resource Navigator - 14 ▪ At risk users/ presenters to ED - 228 ▪ Intake redesign - 35 ▪ Community partnership projects with patients in target population – 408 Total = **715** Other patients served but not included in above total: ▪ Community partnership projects for vulnerable patients – 2,380	715/ 1,752 = **41%**
2.	North Shore	North Vancouver & West Vancouver	186,776	Testing improve ments and spread	In place	3 in Steering Committee; & 73 in various initiatives	In place	Chronic, co-morbid/comple x medical care needs	**17,570** (includes 2,200 Home Health clients, 15,220 high needs clients	▪ GP care conferencing – 155 patients; ▪ Chronic Disease Nurse* in GP practices – 837 in	2,858/ 17,570 = **16%**

**Counted the higher number between GTN In Emergency Assessment and Telephone Follow-up

[1] *Version # indicates progress using incremental improvements; if your HA uses a stages of implementation framework, please indicate that status/iteration)*

[2] *Reach = number of patients receiving services (cumulative count)/ number of patients in target population (actual as per case definition, or estimate)*

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

									and clients of chronic disease nurses/coordinator)	regular caseload ▪ High Needs Clinic – 56 ▪ aIPCC projects – 1,810 (ESD-234;AURAA-147; GTN-1,122**; AHBT-307) ▪ Community partnership projects with patients in target population – 54 Total = **2,858** Other patients served but not included in above total: ▪ Chronic disease nurse coordinator – 98 (most likely included in the 837 above) ▪ Community partnership projects – 3,434 (for mobile and active seniors and not likely to be Home Health clients or high needs patients)	
3.	Richmond	Richmond	189,027	Testing improvements & Spread	In place	17 in Steering Committee and working groups; 130 in the pilot or spread of various	In place	Frail elderly: age 80+ and 70-79 with Alzheimer/ dementia	7,178 (age 80 & over) + 10,592 (age 70-79) = **17,770** *Note: Age 70-79 was added because GTNs target age 70 & over*	▪ GP Care conferencing –105 patients ▪ Screening-Tracking Tool – 46 (20 testing + 26 spread) ▪ Chronic Disease Nurses – 410 (372 in GP practices* and 38 in CD Management	4,776/ 17,770 = **27%**

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 2) – June 16, 2013 to September 15, 2013

						initiatives				Clinic) ▪ aIPCC – 4,215 (ESD-153; AURAA-131; GTN-3,750**; AHBT-181) Total = **4,776** Other patients served but not included in above total because of possible double count with abovelisted projects: ▪ Medication Card – 44 patients during trial phase; ▪ Seniors resource List - 278	
4.	Howe Sound	Pemberton Squamish Whistler	33,458; Pemberton on y=5,118	Planning	In prog-ress	2 in Pemberton IPCC Committee	In progress in Pembert on	Population in Mt. Currie Reserve and Southern Stl'atl'inx	**1,800**	▪ Chronic Disease Nurse in GP practices – 100 from First Nations communities ▪ Community partnerships – 66 Total = **166**	166/ 1,800 = **9%**
5.	Vancouver - Downtown Eastside (DTES)	Downtown Eastside Core	61,242	Testing improve ments	In place	8 in IPCC Steering Committee and Working Group; 24 involved in the care of 89 patients	In place	Complex marginalized population	89 High ED users of St. Paul's Hospital – visited 10+ during the year; 700 people living in 8 SROs Total = **789**	• Integrated care process - 45 patients • Primary outreach services teams in 8 Single Room Occupancy hotels (started under IHN) -700 patients Total = **745**	745/ 789 = **94%**
6.	Vancouver	All LHAs except DTES	568,663	Spread	In place	GPs of moderate to high risk	In place		Complex patients *Note: Although no formal IPCC*	• Chronic Disease Nurses in GP practices* - 332 in	24,749/ 255,001 = **12%**

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 2) – June 16, 2013 to September 15, 2013

						patients			*table, the target population of initiatives is the complex population, an indicator of which is the RUB score. RUB 3, 4 & 5 (moderate, high and very high morbidity =* ***255,001***	regular caseload • GP care conference – 145 • Ideal Transition Home – 4,663 patients • aIPCC – 19,447 (ESD-229+310 from PHC; AURAA-106;GTN**-13,584 + 2,317 SPH and 2,047 MSJ; AHBT-671+183 PHC) • Community partnership – 162 Total = **24,749**	
7.	Sunshine Coast	Sunshine Coast	28,936		In place		In progress				
8.	Bella Coola Valley and Central Coast	Bella Coola Valley & Central Coast	4,290								

* Chronic Disease Nurses in GP practices under the IHN model will be combined with IPCC in the care model that the community decides

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 2) – June 16, 2013 to September 15, 2013

SUMMARY as of September 15, 2013

	Community	Target Population	Patients receiving services	% of target population receiving new services
VCH	Powell River	1,752	715	41%
	North Shore	17,570	2,858	16%
	Richmond	17,770	4,776	27%
	Pemberton	1,800	166	9%
	Van. DTES	789	745	94%
	Vancouver	255,001	24,749	10%
VCH		294,682	34,009	12%

Note: Vancouver's target population are those with moderate, high and very high morbidity (RUB 3, 4 and 5) instead of just high and very morbidity persons (RUB 4 and 5) as was done in the Q1 report.

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 3)

	Community Based Service Delivery Areas **2011/2012**	Collaborative Services Committee priority issues/ <List-may coincide with CSC agendas or IHN Steering Committee Agenda> Below are VCH Local IPCC Steering Committee agenda/issues: Pls. update this column	Describe planned new or redesigned services (and % implemented) < describe **key integration** activities that are being prototyped; **include numbers of other providers** such as case managers, nurse practitioners etc >	Patients as Partners Specific examples of how this service delivery element is being embedded by CBSDA i.e. Patient/community partner on CSC; training etc	Care Planning - Coordinated / Shared Care Plans (key elements or, operational definition ; # shared care plans per GPSC billing fee)
1.	Powell River	▪ Sharing of information between GPs and VCH home health & mental health teams ▪ Shortage of Physicians ▪ Timely communication ▪ Shared care plan – eventually electronic ▪ Building community partnerships	▪ Intake Liaison redesign ▪ Home health service redesign ▪ Connecting pregnancy (Interdisciplinary primary maternity care group visits) ▪ "At-risk" users/presenters to ED ▪ Health Resource Navigator ▪ Community partnerships	▪ Patient representation in IPCC planning such as regional and local IPCC steering committees or working group ▪ Formal orientation of patient representatives before involvement in steering committees/working group ▪ Various ways of capturing patient voice such as patient survey, focus groups and patient journey mapping in improvement initiatives ▪ Involvement in care conferencing and shared care planning	Care planning is done as part of case conferencing between GP and community care providers e.g. case manager, home care nurse. Possible measure is: ▪ Patients in the target population who have a care plan in VCH's PARIS (Primary Access Regional Information System) or paper-based tracking system e.g. in integrated care for high ED users/complex patients in DTES
2.	North Shore	▪ North Shore IPCC Steering Committee had a strategic planning meeting in April 2013 to discuss priorities to be focused on in the upcoming year. The priorities include, Home Health Redesign, High Needs Clinic, First Nations	▪ GP care conferencing ▪ Home and Community Care intake redesign ▪ Chronic Disease Nurse Coordinator Program ▪ Smart phone app on programs and services ▪ High Needs Clinic ▪ First Nations initiatives ▪ Community partnerships	Same as above	Same as above

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

		Health, GP/Primary Care engagement, Public Support/Community engagement			
3.	Richmond	▪ Proactive frailty assessment of all people age 80+ ▪ Improved communication and interaction of among team of care providers ▪ Improved transitions from Acute to primary and community care (pilot project) ▪ Improved patient accessibility to chronic disease management support (Launching of a centrally located clinic)	▪ Standard referral form for all home health services and LTC 1 assessment report to GPs ▪ Screening-Tracking Tool for the frail elderly ▪ Medication management ▪ Senior's Community Resource List and Key Community Agency Partnerships ▪ Chronic Disease Management Clinic ▪ GP care conferencing ▪ Early Supported Discharge ▪ bestPATH ▪ Community partnerships	Same as above	Same as above
4.	Howe Sound - Pemberton	▪ Building on integration practices in current system ▪ Integration between services at Pemberton Health Centre and Mount Currie and Southern Stl'atl'inx Health Centres	▪ Telehealth ▪ Transportation services inventory ▪ Tool to educate staff discharging patients to Pemberton and surrounding areas ▪ Cultural day ▪ Community partnership	Same as above	Same as above
5.	Vancouver - Downtown Eastside (DTES) Core	▪ Downtown Eastside Second Generation Strategy with the vision of integration of care through better coordination of health providers and community agencies	▪ Integrated care process for complex patients ▪ Consultation process to develop the DTEs Second Generation Strategy ▪ Primary Outreach Services ▪ Community partnerships	Same as above	Same as above
6.	Vancouver	▪ Home health redesign ▪ Transitions and care coordination for patients discharged from acute care	▪ Ideal Transition Home initiative ▪ Care conferencing ▪ Community partnerships	Same as above	% of time transition plan transferred with patient (Mod/high risk)

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 3)

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

INTEGRATED PRIMARY AND COMMUNITY CARE

QUARTERLY REPORT (Section 1)

Health Authority : Vancouver Coastal Health	Reporting Period: September 16 to December 15, 2013
Compiled by: Venie Dettmers/Carol Park	Submitted to MOH: December 20, 2013

Summary of Major Progress and Key Accomplishments Since Last Report

Macro (across HA):

A. Accelerated Integrated Primary and Community Care Initiative (aIPCC)

In addition to integration projects under the IPCC bilateral agreement, the projects listed below are being implemented with Accelerated IPCC funding. Separate progress reports are submitted to the Ministry. However, an update on Care Management/Home Health Redesign is included below and a number of patients served in all aIPCC initiatives are included in Section 2 of this report.

- ***Avoidance of Unnecessary Residential Care and Acute Admissions (AURAA)*** Provides an enhanced home based service to clients who would otherwise be moved to residential care. Care is provided by an interdisciplinary team with the following focus: intensive care management and an enhanced mix of community-based services designed to meet the needs of clients with multiple, complex and interacting chronic diseases and/or social and environmental factors.

- ***Early Supported Discharge*** In collaborative partnership with GPs, an interdisciplinary community reintegration team supports patients with COPD, CHF and stroke through an early discharge from acute care. The team provides short term rehabilitation for up to three months that includes: coordination, education, and provision of self-care management education and support to patients and caregivers to enable them to have knowledge and skills needed to manage their chronic condition.

- ***Frail Seniors Transition*** Expands interdisciplinary teams that address the community transition needs of older adults (70 + years) who present to ED to support prevention of unnecessary acute care admissions, provide seamless transitions to community and primary care resources after an emergency visit, and provide a coordinated approach to manage complex geriatric issues. The teams include geriatric triage/emergency nurses, transitions nurses for follow up support in the community and community-based pharmacists.

- ***Acute Home Based Treatment (AHBT)*** Provides home-based treatment for mental health and addictions clients as an alternative to hospitalization. The AHBT team consists of psychiatrists, clients, families, GPs and nursing staff supported by social workers, counsellors, or rehabilitation professionals as required. This team follows clients and provides intensive short-term treatment for up to 21 days in the clients' home.

- ***Assertive Community Treatment (ACT)*** A client-centered, recovery-oriented mental health service delivery model, the ACT team is mobile and delivers services in community locations to enable clients to continue to live in their community. This service is provided 24 hours a day by a multidisciplinary team, including a GP, with a low client to provider ratio. The expansion of ACT teams is in its early phase.

▪ ***Care Management/Home Health Redesign*** Aims to redesign VCH Home Health services to align with the provincial care management strategy and integrate teams with primary care in each community. The components are inter-professional care conferencing between GP and home health team members , telephonic care management and provider education

Since September a number of activities have occurred.

- A physician reference group has been established to provide on-going engagement with the Initiative
- Patients/Clients have been brought together into focus groups and interviews to provide a baseline understanding of current patient experience
- Current state mapping activities have occurred at a regional level
- Managers were brought together to provide input and discuss the 2014 roll-out process
- The IPCC team has become more aligned with and has become an integral partner with the Home Health Redesign Initiative
- The IPCC Leads and IPCC evaluators will be highly involved with the Home Health Redesign Initiative which is seen a major component of overall IPCC work.

B. Other Region-wide Integration Initiatives

▪ ***First Nations/Aboriginal Initiative –*** The goal is to facilitate the integration of the First Nations and Aboriginal services with the IPCC work. A Regional working group meets regularly and consists of members of the Regional IPCC Team, VCH Aboriginal Team, First Nations Health Authority and the VCH-IPCC Aboriginal/First Nations advisory team which facilitates engagement with First Nations and community members to develop local vision and priorities for IPCC. Highlights during the reporting period were:

- The inventory/map and analysis of "Availability and Levels of Access to Primary Health Care Services in the 14 First Nations Communities (on-reserve)" was disseminated to concerned parties internally and externally.
- An inventory/map of services used by Aboriginal people off-reserve/urban areas in Vancouver, North Shore and Richmond was completed in draft in November 2013 and is being presented to VCH Senior Executive Team in December
- Engagement with First Nations communities was facilitated for the following VCH initiatives:; Nurse Practitioner proposals were supported in urban Vancouver for Musqueam and Urban Native Youth Association with Providence Health; support was provided for the 3 First Nations affected by the transition of services from United Church to VCH in the Central Coast targeted for completion by March 2014
- First Nations Health Directors from Sliammon, Mt Currie & Southern Stlìtlìmx Health Society (4 First Nations), and Squamish & Tsleil-Waututh First Nations are members of local community IPCC steering committees in Powell River, Pemberton and the North Shore, respectively.
  Joint IPCC initiatives are described in this report under each community.
- Results of reflections/survey on First Nations/Aboriginal Initiative progress were finalized and provided to IPCC Leads/Evaluation Team for presentation to IPCC Steering

Aboriginal FN Initiative Combined Su

Committees, etc.

- ***Regional Intensive Complex Patient Care Planning (RICP2) Initiative –*** The goal is to create a regional care planning process that ensures a comprehensive approach to caring for patients who frequently visit or use the Emergency Department for complex and/or chronic care management issues. The focus is on those who visited more than 1 urban ED site 20+ times during the year, and are referred to as "Familiar Faces".
  - From May 1, September 30, 2013, a PDSA trial phase for developing and initiating an integrated community based approach to care planning was completed. A total of 12 Shared Care Plans were developed by the most responsible person in the community, in collaboration with the GP, any specialists, and the Emergency Department medical staff.
  - Another PDSA starting November 1, 2013 is now underway with the same objectives, however, with the goal of completing in a shorter time frame.
  - Frontline/Manager Focus Group: was held in November 2013 and provided feedback to the Project Team on what was working and not working in the project so far. As a result of the feedback, changes were made in processes. The project was presented at the National Reducing Hospital Readmissions & Discharge Planning Conference, Vancouver, October 2013.
  - The project will be presented at the BC Quality Forum 2014.

- ***Updating of the VCH Integration and Performance Measurement Framework*** The Framework and the companion evaluation plan were completed and presented to the IPCC Regional Steering Committee. The Framework and Evaluation plan are now being used to guide all initiatives and evaluations including the Home Health Redesign Initiative and Regional standardized survey questions are being developed including provider (staff & GP); physician engagement, patient engagement, and patient experience.
- ***Regional Steering Committee Survey: The survey report was finalized*** and ***distributed to all the IPCC*** Leads & Evaluators for presentation at the IPCC Committee meetings. Each community report showed that community responses in relationship to regional results. For illustration, Powell River is attached.

IPCC Regional Steering Committee S

QUARTERLY REPORT (Section 1)

Meso and Micro (for specific populations or patient groups; by CBSDA):

1. Powell River

- Powell River IPCC Steering Committee New Director for VCH Powell River officially started September 2013.

- Physician Engagement Strategy Working in collaboration with the local Divisions of Family Practice to continue to engage physicians in the redesign work.

- The following improvement projects are being implemented to achieve integration of care:

1. **Intake Liaison Redesign Integration Initiative** Completed. Project was evaluated and results shared as part of the PR IPSI project. Project is being presented at the BC Patient & Safety Quality Council Conference in February 2014 in partnership with the Integrated Practice Support Initiative (PR Divisions, Practice Support Program, Physician Information Technology Office, and Health Authority)

2. **Home Health Service Redesign** To better meet the need of clients, changes in practice of Home and Community staff are being implemented as part of the Care Management Strategy. ***Stage of Project***: ***Testing***. As the prototype community, future state maps for the six populations of home health clients have been developed. The five population groups identified are: Chronic Co-Morbid; End of Life/Palliative; Adult Living with Significant Disability; Post Surgical/Episodic; and Frail/Complex Older Adult/ Dementia. Job descriptions have been finalized. Have started to use the new standard operating procedure for priority setting of all new referrals. Standard Operating procedures are being tested (PDSA cycles).

3. **Connecting Pregnancy Program** Completed. Project is being presented at the BC Patient & Safety Quality Council Conference in February 2014


Eval Summary Report of Connecting


Connecting Pregnancy Evaluation

4. **"At Risk" Users/Presenters to the ED** The objective is to better respond to "at-risk" or "high use" patients whose care can be improved by better coordination through the Powell River Hospital Emergency Department. The focus is on the following areas:

   - **Mental Health (MH) or Addictions Crisis:** Evaluation took place including provider surveys and key informant interviews. Report to be developed in January 2014. Project is being presented at the BC Patient & Safety Quality Council Conference in February 2014

   - **Rapid Process Improvement for Patients with No Family Doctor** ***Stage of Project*****:** ***Spread.*** A workshop was held in March to reduce the number of ED visits by patient with no family doctor (NFD) and ensure that comprehensive care is provided to patients right care for the right patient in the right place at the right time. Evaluation is taking place including survey of emergency staff and emergency physicians to obtain feedback on process and improvement. Report to follow in January 2014.

5. **Health Resource Navigator –** The objective is to assist physicians in identifying available health and social support services and linking patients to these services. The Resource Navigator will be responsible for sourcing available community, regional, and provincial health and social support services and will determine the best method of keeping up-to-date listings of these services and the best methods of communicating this information to physicians. The navigator will support physicians in linking patients to the most appropriate service. ***Stage of Project: Testing***. Approx 40 requests have been received from family physicians regarding available services in the community. Opportunity arose for the Resource Navigator to provide services to the emergency department. Pilot will begin January 2014. Evaluation is on-going.

6. **Integrated Practice Support Initiative (IPSI) Powell River Initiative** The feasibility study is completed. Plan is to establish and going Practice Support Committee which will include the Health Authority. The report was presented to GPSC and was well received as a model for the rest of the Province. Project is being presented at the BC Patient & Safety Quality Council Conference in February 2014[1]


PR IPSI Appendix 1 Making the Case.pdf


PR IPSI Appendix 2 EMR Intake Process


PR IPSI Final Report for GPSC.pdf

7. **Shared Care Initiatives** The objective is to ensure that primary care is delivered and managed by family physicians with ready access to specialist physician advice and support. The focus in Powell River is palliative care. ***Stage of project: Planning.*** Current state is being assessed and stakeholders engaged in order to identity gaps and move forward with a full shared care proposal.

8. **Community partnership** projects funded in 2013/14 and their status based on Q1/April-June report are the following:

   - ***Building Recovery of Individual Dreams & Goals through Education (BRIDGES) (BC Schizophrenia Society):***
     Purpose of the program*:* help people understand and recover from mental illness. A course taught by consumers for consumers to empower people with tools that will help them in their journey to recovery. Meetings are held the third Monday of each month from 7:00 to 8:30 pm, in the meeting room on the third floor of the hospital.
     - Total of 40 clients served since start of VCH funding. Average of 20 clients per month accessing the program
     - Age range of clients: 46 55 years old
     - Gender: 16 male and 24 female
     - Health issues: diabetes, chronic pain, depressions, asthma, arthritis, substance abuse
     - Social issues: social isolation, financial challenges, housing, family alienation

     Key Successes:
     - has provided clients with motivation to take other courses
     - has helped overcome social isolation
     - Gives people purpose and helps them establish a routine rather than feeling there is no reason to get up in the morning.

- ***Powell River Employment Program Society*** provides two programs to the community for:
  - Clients with health issues: diabetes, chronic pain, depression, asthma, arthritis, heart disease, addictions, HIV and other communicable disease, and mental health;
  - Social issues: social isolation, financial challenges, housing, and food security

  - ***Humble & Hearty Workshop***
    Purpose of the program: Deliver 18 participatory workshops annually to show low-income clients with chronic health conditions how to cook healthy meals using low-cost ingredients.
    - Total of 333 clients served since start of VCH funding. Average of 19 clients per month accessing the program.
    - Q1 referrals: Total of referrals 54 of which 48 were self referrals
    - Gender: Male 50% Female: 50%
    - Age range of clients: 26 65 years old
    - 6 workshops offered; 16 people participated of which 11 have attended more than one workshop.

    Key Successes:
    - Relationship building, good friendships and mentoring.
    - Participants value the program
    - Participants acquire new cooking skills and ideas for healthy eating on a limited income
    - Development of a new cookbook
    - Clients are excited about each workshop and most claim to have used the recipes at home
    - Clients have changed their eating habits and lost weight

  - ***Monday Brunch***
    Purpose of the program: Increase access to meals for people with chronic health problems and increase access to public health professionals and other educational and social supports.

Brunch July-Sept 2013 (2).rtf

- ***Promoting Community Wellness (The Source Club Society)***
  Purpose of the program: Promoting community wellness and providing people living with mental illness with social and recreational activities, opportunities to engage in health practice.
  - Total of 399 participants since start of VCH funding.
  - Gender: Male 10% Female: 90%
  - Age range: 26 65 years old
  - 26 workshops completed with 22 repeat participants.
  - Total of 8 referrals (7 self referral and 1 from other agency)
  - Health issues: depression and arthritis

- Social issues: social isolation, financial, and food security
- The Yoga Program continues to support the participants' needs for mental and physical fitness. Focus has been on strength, flexibility, balance and relaxation.

On an average 6 participants and on occasion 8-10. Key Successes:

- Clients report less pain and feeling of well being
- Participants commented that there is an improvement in their flexibility, strength, and balance. Some participants are moving into intermediate Yoga poses.
- People are engaged and return regularly to the sessions

2. North Shore

- Key activities related to the North Shore IPCC Steering Committee:
  - All North Shore strategic priorities are standing items discussed at each meeting. Strategic priorities include Home Health Redesign, Aboriginal Health, GP and community engagement, and the High Needs Clinic.
  - The Committee aims to have at least one guest speaker present at each meeting. Steering Committee's Terms of Reference has been reviewed.
  - First Nations Working Group (North Shore/Coastal) The purpose of this working group is to improve linkages and communication among First Nations Health Centres, Lions Gate Hospital, Primary Care and Mental Health & Addictions particularly around discharge coordination

- The following improvements are being implemented to achieve integration of care:

1. **GP Care Conferencing** Care conferencing in person or over the phone between Home and Community Care (HCC) staff was rolled out beginning of October 2012. This rollout builds on the pilot testing of care conferencing with case managers in late winter/spring 2012. ***Stage of Projec***t: ***Spread***. Process has been rolled out to all HCC clinicians. Workflow has been established and clerical support implemented to arrange conferences for clinicians. To date, 161 clients have had care conferences conducted on their case. In total 84 GPs have engaged in care conferencing with 44 HCC staff.

2. **Home and Community Care Intake Redesign** In response to a Lean analysis recommendation, an intake clerk position was created to reduce the amount of non-clinical administrative work such as faxing, collecting demographic information by intake nurses, and having 'live' clerical support answering calls. ***Stage of Project: Sustainment***. As of December 2012, a new workflow has been established in order to reduce the bottleneck of referrals and increase feedback and communication to GPs on the status of the referral to Home & Community Care.

3. **Chronic Disease Nurse Coordinator Program** The objective is to support family physicians in providing comprehensive, guideline-based care to their complex patients with two or more chronic conditions. A key change idea for this program is that the CDN Coordinator is housed in a central location at a Community Health Centre rather than embedded in a Family Physician's private practice. ***Stage of Project: Sustainment***. To date, a total of 129 clients from 35 different GPs have been referred to the program. Of the referring GPs, 14 (40.0%) have referred more than 1 of their patients to the program. There are 100 currently active clients in the program (and 29 clients who have been discharged). Additional presentations to GPs and other VCH programs continue in order to increase program awareness and number of GP referrals.

4. **Smart Phone App** The objective is to make information about programs and services that support the health and wellness of the North Shore population accessible to physicians and their MOAs. A directory of physicians indicating their specialty has been incorporated into the App and its web-based version (the latter intended for those without a Smartphone). ***Stage of Project: Deployment pending.*** Practitioner data has been entered and coding has been refreshed for the mobile App and on its website/server side. App developers are waiting for go-ahead to deploy to the App Store and third party host server. Consultation with VCH Information Privacy Office has been completed. VCH Legal has requested revisions to the service agreement, which are being reviewed by the in-house legal counsel of the provider. Once an agreement is reached the developers can deploy the app server.

5. **High Needs Clinic** The objective is to provide supportive, low-barrier primary care services for North Shore residents with complex medical and social needs and no regular access to a family doctor or nurse practitioner. The clinic is a partnership between North Shore Division of Family Practice and VCH with additional support provided by the Physician Information Technology Office and the Practice Support Program. The clinic is currently open to see clients Monday to Friday between 9AM and 12noon. The clinical staff includes GPs, NP, CDN and MOA. On Monday, Wednesday, and Friday a GP is available to see clients and on Tuesday and Thursday, a Nurse Practitioner is available. The Canadian Mental Health Association, Lookout Society and Hollyburn Family services have outreach workers and social work practicum students scheduled to work out of the clinic to provide non-medical supports to clients. North Shore Neighborhood House can also support clients of the clinic. ***Stage of Project: Implementation***. The high needs clinic has been named the North Shore *HealthConnection* Clinic (same branding will be used for the Smartphone App, another initiative made possible through partnership between VCH and the Division of Family Practice). Several presentations on the Clinic have been made to various teams and departments across VCH. Relationships have been built to ensure clients are referred from LGH, and in particular the emergency department, to support access and flow in acute settings and provide the right care in the right place. More than 50 people (including VCH staff and senior leadership, as well as community service providers) attended the Clinic Open House held on September 30. The Steering Committee and various sub-committees continue to meet to refine processes, workflows and clinic forms. Operations meetings with clinical staff are now regularly held. An EMR has been selected and work is underway to implement the EMR in the next few months. A robust evaluation is in progress to assess how well clinic aims (to reduce health care utilization, improve health outcomes, and improve the client experience) are being met. To date, 418 visits to the clinic have been made. Of these, 119 were new client visits. An average of 4 visits per day is made to the clinic (with as many as 9 clients being seen on one day). 79 clients have made 2 or more visits to the clinic. Preliminary evaluation outcomes and an overview of the unique aspects of the clinic model and funding will be presented as a Poster Presentation at the Quality Forum in 2014. A copy of a recent presentation on the clinic is also attached.

HealthConnection Presentation Updatec

6. **Integrated Practice Support Initiative (IPSI) North Shore Initiative** The objective is to strengthen the delivery of quality practice support by aligning PSP and PITO practice support

services. Evaluation occurred in Sept-Oct 2013 and included a team reflective survey, Key informant interviews, as well as the results from the High Needs Clinic. An interim report was presented to GPSC in November. The IPSI project has the go ahead to continue the project until March 2014. Plans for January-March are to be developed in January.

7. **Shared Care Initiatives** The objective is to ensure that primary care is delivered and managed by family physicians with ready access to specialist physician advice and support. Areas of focus in the North Shore are orthopaedics, mental health and oncology.
   Orthopaedics ***Stage of project: Testing and scaling up*** for the following projects: advice line, centralized referral system, screening clinic, referral acknowledgment and consult template and sharing of care. And ***Planning stage*** for accurate identification of family physician upon acute admission.
   Mental health ***Stage of project: Testing and scaling up*** for one time consult followed by group visits. And ***Innovation development*** for transitions into and out of acute and referral processes to psychiatry.
   Oncology ***Stage of project: Innovation development*** for rapid access to breast cancer care and specialized role of a family physician in oncology.

8. **Community partnership** projects funded in 2013/14 and their status in Q1 (July-September) are the following:
   - ***Counseling Service for Patients with Complex Health Issues*** - Individual and group counselling for individuals experiencing mild to moderate depression and chronic illness. Number of referrals received: 23; Patients seen during the quarter: 16. An evaluation of the program was undertaken in the fall of 2013. Results indicate that clients' PHQ-9 and GAD-7 scores (mental health assessment tools) all improved as a result of being in the program. In addition, clients were extremely pleased with the program and spoke about their appreciation for this type of program being made available, at low cost, for people who are struggling with mental health issues and chronic diseases.
   - ***Peer Support for Health and Wellness*** - offers one-on-one emotional support, guidance regarding life changes and challenges, as well as provide resource information. Number of intakes from community: 13 who were provided 100 support hours.
   - ***North Shore Keep Well*** - an exercise and wellness program for mobile seniors to encourage and help older adults to keep well by leading active and independent lives. The program includes one hour of exercise followed by blood pressure checks and health coaching, massage, speakers and social times. Total attendees during the quarter in 7 sites: 2072.
   - ***Golden Circle*** offers wellness and leisure education to frail seniors who may have challenges accessing programs. It includes out-trips, healthy snacks/social time, education speakers, brain and memory games, chair exercises and other recreational activities. Total number of participants for the quarter: 348
   - ***First Link*** a first response strategy for people newly diagnosed with dementia and their families. It includes proactive outreach, information and connections, and planned follow-up. In order to ensure that services appropriate to people with early symptoms of dementia are available in the community, Minds in Motion™ and Shaping the Journey: living with dementia™ are implemented alongside First Link®.
     Status in the North Shore and Sunshine Coast is as follows:
     - Number of referrals received during the quarter 28 with majority coming from

assessment clinic/specialist.
- Number of active cases to date - 28
- Number of Shaping the Journey participants 11
- Number of Minds in Motion Participants 39
- Outreach to health professionals/Number of meetings and presentations - 2

- ***Volunteer Drivers –*** Run by North Shore Neighbourhood House, the medical rides pilot project uses NSNH trained peer support volunteers who donate their time and personal vehicle to transport and accompany complex clients to and from their medical appointments and treatments. This service is structured similarly to Capilano Community Services Society medical rides program, but draws from a different pool of volunteers with senior peer support training. Number of rides: 5 and number of volunteers: 6. A process evaluation was completed for this program in the fall of 2013. The evaluation found that both drivers and seniors using the service are extremely pleased with the service. The evaluation also identified some areas for improvement, specifically around the referral process, which the program is now working on.

4. Richmond

- Key activities related to the Richmond IPCC Steering Committee:
  - Monthly meetings held with IPCC Co-Chairs (VCH Primary, Home and Community Care Director and Family Physician, DoFP Board Member) to plan agenda for the upcoming IPCC Steering Committee meeting.
  - Mike Nader, COO VCH Richmond provided an overview of CST (Clinical and System Transformation) to IPCC Steering Committee. Draft copy of the CST Governance Model shared. This includes the formation of Clinical Design Group which includes Primary Care representation and hence opportunities to voice issues and provide a PC perspective. Mike Nader was also asked to present to the Richmond Medical Advisory Committee.
  - Terms of Reference updated and endorsed by members. In addition, DoFP Executive Director presented the TOR to board members and received approval.
  - IPCC Framework *Building of an integrated primary, community and acute care system* was shared at an IPCC Steering Committee meeting. See below re the various key Richmond initiatives and how they are aligned within the framework.

    IPCC Framework aligned with Richmon
  - Evaluation of the Richmond IPCC Steering Committee completed. Responses of the questionnaire analyzed. The purpose of this survey is to better understand perceptions of the steering committees (areas of success and areas of improvement). Plan is to share the results at an upcoming IPCC meeting and use it as a platform for further discussion re next steps.

- Continued to strengthen linkage and partnership with DoFP
  - DoFP held an MOA event on Sept 17. Approximately 40 MOAs attended. Richmond IPCC Lead provided information on 3 integration improvement tools to the MOAs. This included: Screener Tool, Seniors Resource and Support List; and GP Care Conferencing.
  - Submission of brief synopsis regarding Frail Screener Tool to the DoFP newsletter

- Ongoing work /partnership with PSP to leverage integration work
  - Information re GP Care Conferencing initiative shared at the End of Life Module 3rd session in the fall. 27 Richmond Family Physicians attended. Copies of the brochure re the Chronic Disease Management Clinic were also made available.
  - PSP Lead (during December) will be delivering Seniors Resource & Support Folder to those 38 GP Practices who previously have indicated an interest in receiving a copy.
  - Continue to work closely together to look for opportunities to highlight integration initiatives.

- The following improvements are being implemented to achieve integration of care:

1. **Standard Referral Form and Long Term Care 1 (LTC1) Report** The objective is to streamline the referral process from GP to HCC and feedback to GPs. The HCC referral form has been redesigned and a feedback loop confirming services to the GP is part of SOP. A LTC 1 Report will be faxed to GPs regarding new clients referred to Case Management. ***Stage of Project***: ***Sustainment*** (HH referral form spread to all the 130 GPs*)*. Tracking results indicate referrals forms are being completed appropriately with very little error or misses. Report regarding key insights and experience of the process is being developed.

2. **Screening Tool for Frail Elderly** This one-page screener was developed with Family Physicians to use in their practice to actively case find frail elderly patients who could benefit from referral to Case Management (CM) service and to proactively identify clients who are not eligible for CM, but are at risk and may benefit from social supports and services available in the community. ***Stage of Project: Spread***. The tracking of the screener tool indicates that as of December 2013, 37 tools were completed.

   The challenge is how to continue raising awareness regarding the availability and usefulness of this tool to Richmond Family Physicians. In order to address this, a brief description of the Screener Tool for Frail Elderly was inserted in the October DoFP newsletter. In addition, a copy of the tool and communication letter will delivered/shared by the PSP lead at the same time the Seniors Resource list is being delivered to the targeted GP Practices. Other opportunities will be considered whereby the Screener tool can be shared. For example, at the PSP module End of Life.
   An evaluation is being planned in the New Year to determine the usefulness and effectiveness of the tool during the spread phase.

3. **Medication Management** The objective is to create an accurate patient medication list to improve communication and interaction within the inter-professional team resulting in coordinated care, awareness of patient status and reducing duplication of work and frustration. ***Stage of Project*: Completion of the pilot phase.** An evaluation was carried out to determine if the creation of an accurate patient medication card (BC Patient Safety and Quality Council medication card) improved communication and interaction within the interprofessional team resulting in coordinated care, awareness of patient status and reduction in duplication of work and frustration. There are however, limitations to the evaluation of this initiative. This includes: only 4 GP practices responded to the post survey; no patients completed the post survey and the feedback from the Home Health nurses, although valuable was provided through an informal process. Highlights of the key findings indicate:
   a) The **concept** of developing an accurate medication card/list is of great value as reported by

the HCP participants. (This allows patients to better communicate with their GPs and other health care providers in order to enhance management of their medication, decrease adverse reactions and decrease the risk of ED visits/hospital admissions).

b) The BCPSQ medication card needs to be improved. Some of the HCP participants indicated the card was not useful in practice
c) Patients often developed their own way of tracking their medications
d) What is the role of the pharmacist in helping to inform/develop an accurate medication list for the patient to be explored further.
e) A need to share/keep track of over the counter/non-prescription/vitamins and herbal medications was identified.

The sub-working group has been invited to share these findings with the VCH Regional Medication Reconciliation Committee in January 2014.

In addition, a list of services provided by Richmond pharmacies to clients in the home that are challenged by mobility and cognitive issues are now being compiled. The intent is to create a handout that can be used by primary and community care providers with their patients/clients who face challenges getting to an in store pharmacy.

4. **Senior's Community Resource List and Key Community Agency Partnerships** The objective is to develop one resource list for GPs and other health care providers to use in their practice that includes non medical supports and services available in Richmond for seniors.
Stage of Project: Spread. This resource folder is now complete and includes a Mental Health section (based on the feedback from the participants during the trial phase). The folder has been distributed to VCH clinicians (52 Home Health Clinicians and 23 Mental Health). A folder has also been distributed to the Acute Care Social Worker Practice Lead. It is also being distributed to the 38 GP Practices by the PSP Lead. A covering letter was developed and co-signed by the IPCC Steering Committee chairs. See below.


GP Cover Letter.pdf

The resource list will also be made available for download on the VCH Primary Care website which will be now launched in January 2014. In addition, Family Physicians will be able to access the VCH Primary Care web link from the DoFP website. The resource list will be updated annually.
An abstract of this initiative was submitted to the Patient Safety and Quality2014 Forum. It was accepted as a storyboard presentation. Here is copy of the abstract.


BC PSQC Quality Forum2014 Seniors R

5. **Chronic Disease Management Clinic** A Chronic Disease Management clinic was established at 8100 Granville with the objective to engage GPs in referring patients with chronic conditions for comprehensive guideline-based care to a centrally located clinic. Chronic Disease (CD) Nurses (2 of the 5 nurses are able to speak Chinese) will support patients to manage their health conditions. A key change is that CD Nurses can provide support to GPs who DO NOT have a

nurse attached to their practices. ***Stage of Project***: ***Pilot***. To date 18 Family Physicians Practices have been approached. This includes 9 GP Practices who have a predominately large Chinese speaking population. As of December 2013, 71 new patients have been seen.

A key strategy that is currently being addressed is to strengthen the linkage with the ESD program. As patients are discharged from the ESD program, is there an opportunity for the patient to be followed and supported by the CD Nurse if appropriate?

An evaluation will be carried out in January 2014. The evaluation will look at the experiences of patients who have received services by CD Nurses and GPs who have referred patients to the CD Management Clinic. In addition improvement in patient knowledge, confidence and change behaviour will be looked at. A copy of the patient questionnaire is below. This questionnaire will be also be translated in Chinese

RH CDN Clinic Client Survey feedback 810

6. **GP Care Conferencing –** GP Care conferencing initiative was launched in February 2013. The goal of the conference is to improve communication between GPs and HH clinicians around complex patients in order to better meet their health needs. The conferences are scheduled in advance with the GP, thereby ensuring that all participants in the conference have dedicated time to focus on the patient's needs. A regional project team working group has been established to help facilitate the implementation of GP Care Conferencing in regular HH practice at each of the CoC. ***Stage of Project***: ***Spread***. To date, 146 clients to date have had care conferences held on their case.
   In addition, 5 Interdisciplinary District teams have been implemented in Home Health. The goal is for HCPs from multiple disciplines to come together, including Home Support Workers to discuss complex patients. This is an opportunity to also identify client issues and to decide if a GP care conference is needed.
   An evaluation was carried out in the summer; the results were compiled and shared at the September 2013. Majority of respondents indicated that GP Care Conference improved patient outcomes however competing priorities/workload make it difficult to implement in everyday practice.

Richmond GP Care Conferencing Two Pa

   The focus in the new year is to work closer with the district teams and to better address The successes, challenges and logistics around GP Care Conferencing. IPCC Lead and HHR Lean Lead will work in partnership with HH Manager and Director (and with the support of the Regional HHR project team) to move this initiative forward.

7. **Early Supported Discharge -** The objectives are to support early discharge of clients with chronic conditions from acute care; support and improve patient self-management of chronic conditions. ***Stage of Project***: ***Spread.*** An interprofessional working group has been established to lead and facilitate family physician and patient/family input regarding the process and delivery of the program as well as to carry out a robust evaluation. The focus of this group is to

address some of the challenges which include: case finding of clients, GP engagement around GP Care conferencing and the effectiveness of the ESD communication forms/faxes to GP practices.

A GP Focus Group took place and an evaluation newsletter was developed and the results were shared at the IPCC steering committee. For more detailed information, refer to attached newsletter.

RH ESD GP Focus Group Newsletter Aug

8. **bestPath –** (Person-centred, Appropriate, Timely Healthcare) has recently been launched by VCH-Richmond. bestPATH is a partnership between Richmond acute teams, community teams and primary care to improve health outcomes; improve the patient care experience; improve workflows and enhance HCP satisfaction. ***Stage of Project***: ***Spread.*** The bestPATH strategy will roll out in phases starting with the 3 South acute unit team and South community team. Phase I will involve developing a better understanding of the current environment and identify opportunities for improvement with input from all care providers, patients/clients and families. Phase II will see the Steering Committee and Working Groups implement the solutions that have been identified.

   The focus of IPCC with this initiative is too also ensuring that a primary care lens is included. Family Physicians were invited and participated in 5 workshops held in the summer in order to provide an opportunity for input from a GP perspective regarding the current process as the patient journeys from Acute to Community and Primary care. Six Family Physicians participated. In addition, one of the Family Physicians participated in a job shadowing activity in home health to learn about the role of the Home Care provider as it relates to patient care and to gain a better understanding regarding the philosophy and approach that is embedded in Community Health Services. This experience was captured in the DoFP newsletter as well as the VCH Communications. Other GPs have been invited to participate in a HH shadow experience however currently no one has accepted the offer.

9. **Shared Care Initiatives** The objective is to ensure that primary care is delivered and managed by family physicians with ready access to specialist physician advice and support. Areas of focus in Richmond are orthopaedics and rheumatology. ***Stage of project: Innovation development*** for referral processes. The IPCC Integration lead is part of this steering committee to provide a VCH perspective as appropriate.

10. **Community partnership** projects supported in 2013/14 and their status in Q1 (July-September) are the following:
    - ***Wellness Connections Program*** - a transitional therapeutic recreation bridging program that enables frail isolated seniors and people with multiple chronic conditions to identify and master the skills for community recreation participation and community inclusion.
      48 clients participated in the Wellness Connections Program from January December 2013.
      A summary of the report/outcomes is listed below indicating **positive improvements regarding physical status indicators, socialization and mood levels.**

Richmond Wellness Connection 2013 Sur

The program coordinator was invited to a Richmond IPCC Steering Committee meeting. As a follow up, the program coordinator was asked to provide a description of the Wellness Connections program for the DoFP newsletter.

- ***First Link*** a first response strategy for people newly diagnosed with dementia and their families. It includes proactive outreach, information and connections, and planned follow-up. In order to ensure that services appropriate to people with early symptoms of dementia are available in the community, Minds in Motion™ and Shaping the Journey: living with dementia™ are implemented alongside First Link®. Status in Richmond/South Delta is as follows:
  - Number of referrals received during the quarter - 54 with majority coming from assessment clinic/specialist.
  - Number of active cases to date 514
  - Number of Shaping the Journey participants 8
  - Number of Getting to Know Dementia participants 10
  - Number of Minds in Motion participants 47
    - Number of participants in Caregiver Series (Cantonese) - 21
  - Outreach to health professionals/Number of meetings and presentations) - 7

The program coordinators of these two initiatives (along with other Richmond community agencies) have been invited to attend medical rounds at Richmond hospital on Dec 13 to describe their programs, target populations, successes and challenges and how to increase referrals from physicians to their services. Primary care physicians also attend Hospital Medical Rounds.

4. Pemberton and Squamish in Sea-to-Sky

A. The Pemberton IPCC Committee continued to provide support and direction to the identified opportunities for improvement:

- Continued working with First Nation in Mt. Currie to find opportunities to improve integration of services with VCH.
- **Telehealth** The objective is to improve communication between healthcare providers and clients living in rural communities. E20 units have been installed in communities and have been used 20 times in Pemberton to coordinate patient care. ***Stage of Project: Pilot.*** Evaluation feedback shows that both the physicians and the First Nations providers are enthusiastic about the units; however the main issue is larger telecommunications network issues that involve Telus. As a result of these issues, the pilot is stalled until better telecommunications networks are installed.
- **Transportation services** The inventory has been completed. It includes a list of what transportation is available within the community and the services available to Vancouver. Also developed was an inventory of funding sources available to access transportation needs. Next step is to align with the Better at Home work.
- ***Discharge Information form*** The objective is to better support hospital discharges to Pemberton. The form contains information about discharging a patient home to a rural community. Rural communities have specific challenges with transportation, available services and access to specialized medication and equipment. ***Stage of project: Spread***. The form is being used with local hospital staff. Evaluation: informal feedback indicates that the form is

being well received and used at the local level as well as down at Lions Gate Hospital. Providers at Lions Gate have say that the form has made them more aware of how far away the First Nations patients are living and can then make more realistic plans upon discharge. Ongoing feedback will continue to improve the process.

- ***Nurse Practitioners*** are being hired.
- **Shared Care Initiatives** The objective is to ensure that primary care is delivered and managed by family physicians with ready access to specialist physician advice and support. Area of focus in Squamish is oncology. ***Stage of project: Innovation development*** for improved processes for the delivery of chemotherapy within the community; and improved communication and continuity of care between the Squamish physicians and Lions Gate Hospital.

- **Community partnership** project supported in 2013/14 and their status in Q1 (April-June) are the following:
  - ***Bowling for Life*** an opportunity for seniors of Pemberton and elders in Mt. Currie to come together for an afternoon of Wii bowling and lunch. Average number of participants: 66. Evaluation: Informal Feedback from clients indicates a high degree of satisfaction with the program.
  - ***Exercise 4 Brain & Neuro Health in Squamish*** - Program was launched in September 2013. Program was full at 8 participants, 2 on the wait list. The next session will start in January 2013, with the majority of participants opting to sign up for a second session. The aim is to provide exercise and support to patients with neurological conditions such as MS, Parkinson's, and stroke. The program has just reviewed its first 12 weeks of pilot data and found small improvements to the clients' health as a result of the program. Participants were incredibly pleased with the program, that offers tailored exercises to the participants' health condition. Unexpectedly, the program received excellent feedback from caregivers, who said that they had created an informal 'support group' with other caregivers whose family members were part of the program. Further evaluation results will be made available after the winter session.

B.Squamish Integration Table: First Nations Heath Director, local VCH leadership and local Division of Family Practice leadership have been meeting. They have developed a resource sheet with contact information for the Squamish First Nation services. Currently in draft. Next steps finalize sheet and spread to all family physicians in Squamish.

5. Downtown Eastside (DTES) Vancouver

- **Integrated care process for the high ED users –** The objective is to improve care coordination and proactive community-based care planning. The study cohort consisted of 89 clients who visited St. Paul's Hospital ED 10 or more times between April 1, 2011 and February 2012. Five community sites and St. Paul's Hospital ED participated. The integrated care process was piloted from July 2012 to June 2013 and included the following elements: registry, review of client file, identifying primary care lead, reviewing ED care plan, identifying other clinicians, meeting with client, case conferencing with client, developing a care plan, sharing the care plan and care plan follow-up. ***Stage of Project: Sustainment***. The pilot period ended in June with 45 clients receiving some elements of the integrated care process of which 26 have a documented shared care plan. Best practices are being incorporated into everyday work and complex clients will be the target client group. A Best Practice Guidance was developed to document best practices, challenges and lessons learned arising from the pilot project. Evaluation and project closure report is being

prepared. Summer-Fall evaluation included provider interviews and a provider survey. To support sustainment efforts, a process has been established for community sites to receive a quarterly list of their high ED users defined as those visiting St. Paul's ED three or more times during the quarter.

- **Primary Outreach Services Teams** The goal is to provide primary care on site for people who have difficulty accessing care. Teams continued to hold clinics in single occupancy hotels (SROs) and shelters providing mental health, addiction and primary care. They also provide ongoing case management and health care support to 700 clients. ***Stage of Project: Standard Practice.***

- **Community partnerships** Continue to be supported in SROs to provide tenancy supports through the non-profit organization operating the SRO including: Raincity Housing and Support Society, and Portland Hotel Society Community Services.

6. Vancouver

Vancouver Community of Care has initiated projects that facilitate integration of care. They include:

- **Ideal Transition Home (ITH)** The goal is to improve the patient and family experience and provide quality outcomes for patients discharged from VGH and Providence. The interventions are:

  Within 48 hours of admission:

  - *Readmission Risk assessment* score initiated (early identification of patients at moderate to high risk for readmission)
  - *Readmission Risk mitigation checklist* initiated (standardized interventions)
  - *Hospitalization notice* faxed to GP in community
  - *Referral* sent to community for known clients and for assessment for new clients

  And upon discharge:

  - *My Discharge Plan is* completed and given to patient/family and faxed to community and community GP (discharge notification fax).
  - *High risk patients* - Follow up GP appointment made prior to discharge for 48 hours post discharge.
  - *Moderate risk patients* Follow up GP appointment made prior to discharge for 3-5 days post discharge and a follow up phone call to patient/family by Care Management Leader 48 hrs post discharge.

  Stage of Project at VGH: Spread phase. The estimated number of patients that have been discharged through the ITH process since the implementation in February 2012 to end of November was 5,244 of which: High Risk = 2,088 and Moderate Risk = 3,156.

  Stage of Project at Providence: Testing/prototype development of the frontend elements of the Ideal transition home care process.

- **Care Conferencing –** The objective is to better coordinate care between GP and home health staff. ***Stage of Project: Spread.*** To date, 159 clients had a care conference held on their case.

- **Home Health Redesign** - To better meet the need of clients, changes in practice of Home and Community staff are being implemented as part of the Care Management Strategy. ***Stage of Project***: Planning. Current state mapping of home health programs and patient focus groups are underway.

- **Shared Care Initiatives** The objective is to ensure that primary care is delivered and managed by family physicians with ready access to specialist physician advice and support. Area of focus in

Vancouver is internal medicine. ***Stage of Project: Innovation development*** for improved communication with family physicians upon patient's admission; invitation to family physician to take part in the patient's care while they are admitted; and improved involvement with the family physician in the creation of the care plan; notification of discharge to the family physician; and appointment with the family physician within 72 hours of discharge.

- **Community partnerships** supported in 2013/14 and their status in the previous quarter (July-September 2013) are as follows:
    - ***Development of COPD-related Educational Materials with an Appropriate Assessment of Health Literacy and Ethnic Needs (BC Lung Association*) –** The objective is develop, based on inputs from patients and front line health workers, educational materials in English, Mandarin, Cantonese, Farsi, Korean and Filipino to address specific issues such as: Mode of action of medications; How to use different inhaler devices; The role of action plans in COPD; The importance of pulmonary rehabilitation and the key components that a patient may expect to learn; and A patient information sheet to be provided to patients after they have had a COPD exacerbation either after a hospitalization or visit to the Emergency or an exacerbation managed by their primary care physician in the community.

      Modifications were made on educational materials that have been translated into Korean, Farsi, Tagalog, Mandarin and Cantonese. Primary care physicians and respirologists collaborators are being contacted. Pilot testing of the written materials and inhaler videos with COPD patients has started to test the applicability and relevance of the videos and written materials.

    - **Strengthening Community-based Resources for Families Experiencing Perinatal Depression and Anxiety and Their Health Care Providers (Pacific Post Partum Support Society (PPPSS)) –** Information gathered and recordings from patients and healthcare professionals and community support workers will be used to: a) Streamline existing distribution mechanisms for PPPSS resource materials. b) Create new culturally appropriate content for the Chinese, Farsi, Punjabi, and Spanish language informational brochures (Farsi and Spanish brochures do not currently exist). c) Update PPPSS training materials for community-based health care professionals, including the use of video interview segments designed to reduce stigma. d) Make the PPPSS website more engaging, interactive, and culturally appropriate, including the use of video interview segments designed to reduce stigma.

      All planned patient focus groups and video interviews have been completed. Website redesign also completed and new site launched in August. Ongoing activities include primary care physician interviews, editing of video segments, and translation of culturally specific brochure content.
    - **Access For All – Supported Health & Wellness Program (Langara Family YMCA) –** The objective is to provide VCH clients with opportunities and support to improve physical activity and develop exercise habits and healthy lifestyle behaviours. The priority target groups will be clients deemed as high risk for exercise cessation. This project builds off of the current and successful Access for All model while incorporating a consistent, detailed and thorough support and follow-up component.

A joint YMCA and Healthy Living Program leaders meeting was held to solidify the client recruitment process.

- ***First Link (Alzheimer's Society)*** a first response strategy for people newly diagnosed with dementia and their families. It includes proactive outreach, information and connections, and planned follow-up. In order to ensure that services appropriate to people with early symptoms of dementia are available in the community, Minds in Motion™ and Shaping the Journey: living with dementia™ are implemented alongside First Link®.
  - Number of referrals received during the quarter - 63 with majority coming from assessment clinic/specialist.
  - Number of active cases to date 215
  - Number of Minds in Motion Participants 123 in 4 areas: Kitsilano, West End, Marpole-Oakridge Community Centre and Hillcrest Centre. Number of participants in Caregiver Series (Cantonese only) 31
  - Outreach to health professionals/Number of meetings and presentations) 5

- ***Education Programs for People Living with Arthritis-Expansion in Vancouver (The Arthritis Society BC & Yukon Division)*** **-** The purpose is to help patients to learn to live well with arthritis and for health providers to learn about this disease in order to better understand this chronic disease and how to work more effectively with patients. The Arthritis Society will offer a four part education program that includes Arthritis Self-Management Programs and Chronic Pain Management Workshops plus offer a targeted ten workshop series designed to provide information and support in a small group setting.

  Number of participants in Chronic Pain Management Workshop, Sept. 21, Croation Cultural Centre - 11
  Number of participants in Chronic Pain Management Workshop, Sept. 26, Kitsilano Community Centre 23

Key Issues, Dependencies and Mitigation Strategies:

QUARTERLY REPORT (Section 1)

Issues/dependencies/barriers across communities:	Mitigation Strategy:
▪ Home Health Redesign initiative is unfolding and at the fore front.	▪ IPCC team to work closely with Home Health Redesign team to provide the system integration perspective and ensure connection of services with related integration initiatives.
▪ Engagement of physicians and their Medical Office Assistant to create buy-in for integration improvements	▪ Look for opportunities to meet/include MOAs in order to provide information re integration initiatives. Be aware of the challenges they face in their day to day work.
▪ Many Family Physicians have limited understanding re the services provided by Home Health and the roles and responsibilities of community health care providers	▪ Invite Family Physicians to shadow community health care providers in order to gain a better understanding of the philosophy and services provided by Community Health services.
▪ How to ensure best practices/improvements are sustained and become part of everyday practice	▪ Memo from Director regarding transition of project work to everyday work and monitoring of key indicators for a period time
▪ How to better enhance the linkage between integration initiatives and the program based work of HH clinicians. For example is there an opportunity for the Frail Screener Tool to be used in initiating GP Care Conferencing?	▪ Engage HH staff and provide opportunities for discussion around identifying value to their patients regarding such linkages.
▪ How to continue sustaining community programs that are presently receiving IPCC funding however this funding will likely come to an end in 2015?	▪ Start the conversation with Community agencies who are receiving IPCC funds and provide guidance around transition plans that could assist such agencies in sustaining worthy initiatives.
▪ How to continue engaging staff in integration and help them see the value to their patients, to the work that they do and the “bigger picture”.	▪ Provide support to managers/directors in helping them frame the messages around integration, including development of patient success stories. Also, use the integration framework as a tool in helping staff see the bigger picture and how the work that they are doing feeds in the development of building an integrated primary, community and acute care system.

QUARTERLY REPORT (Section 1)

▪ Sustainment of improvements by incorporating them in day to day work	▪ Establishment of indicators to track continuous implementation of improvements

Successes and Lessons Learned:

- Change takes time.
- Leadership is key to the success of an initiative
- Change in leadership may slow down the momentum however there is also opportunity for new ideas, energy, insights and new partnerships.
- Documentation of best practices and lessons learned are useful to inform similar initiatives.
- Change is a progression and priorities need to set

PRESENTATIONS

- RICP2 preliminary results (Startup, C & Cross, L) was presented at the National Reducing Hospital Readmissions & Discharge Planning Conference, Vancouver, October 2013.

▪ ***BC Quality Forum 2014 Abstracts Accepted.*** *Eighteen IPCC Related abstracts were accepted from our team and affiliates for presentation* ***at*** *the 2014 Forum.*

BC Quality Forum
Abstracts Accepted 1

QUARTERLY REPORT (Section 2) – June 16, 2013 to September 15, 2013

	Community Based Service Delivery Areas	Communities included in CBSDA	Total Population of CBSDA	Version #[1] /stage planning & implementation	Division *-In place -In Progress -Not started*	# Family Physicians engaged (re ated to vers on/ terat on)	CSC *-In place -In Progress -Not started*	Target Population(s) *Name (i.e. frail elderly – home health) & Case definition*	# People in the Target Population *(estimate based on case definition - denominator)*	# Patients receiving new or redesigned services *(cumulative # of unique patients)*	% Reach[2]
1.	Powell River	Powell River	19,733	Testing improve ments	In place	2 in Steering Committee & 21 in various initiatives	In place	Very High & High morbidity (esp. w/ cardio-vascular disease or Mental Health & Substance Use problems)	1,722 + 30 from Connecting Pregnancy = **1,752**	▪ Connecting Pregnancy - 30 ▪ Resource Navigator - 16 ▪ At risk users/ presenters to ED - 286 ▪ Intake redesign - 35 ▪ Community partnership projects with patients in target population – 408 Total = **775** Other patients served but not included in above total: ▪ Community partnership projects for vulnerable patients – 2411	775/ 1,752 = **44%**
2.	North Shore	North Vancouver & West Vancouver	186,776	Testing improve ments and	In place	3 in Steering Committee; & 73 in various	In place	Chronic, co-morbid/comple x medical care needs	**17,570** (includes 2,200 Home Health clients, 15,220	▪ GP care conferencing – 161patients; ▪ Chronic Disease Nurse* in GP	4,841/ 17,570 = **28%**

**Counted the higher number between GTN In Emergency Assessment and Telephone Follow-up

[1] *Version # indicates progress using incremental improvements; if your HA uses a stages of implementation framework, please indicate that status/iteration)*

[2] *Reach = number of patients receiving services (cumulative count)/ number of patients in target population (actual as per case definition, or estimate)*

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

				spread		initiatives			high needs clients and clients of chronic disease nurses/coordinator)	practices – 837 in regular caseload ▪ High Needs Clinic – 119 (79 of these clients have made 2 or more visits to the clinic to date) ▪ aIPCC projects – 3,541 (ESD-291;AURAA-165; GTN-2,699**; AHBT-386) ▪ Community partnership projects with patients in target population – 54 ▪ Chronic disease nurse coordinator – 129 Total = **4,841** Other patients served but not included in above total: ▪ Community partnership projects – 3,434 (for mobile and active seniors and not likely to be Home Health clients or high needs patients)	
3.	Richmond	Richmond	189,027	Testing improvements & Spread	In place	17 in Steering Committee and working groups; 130 in the	In place	Frail elderly: age 80+ and 70-79 with Alzheimer/ dementia	7,178 (age 80 & over) + 10,592 (age 70-79) = **17,770** *Note: Age 70-79 was added*	▪ GP Care conferencing –146 patients ▪ Screening-Tracking Tool – 57 (20 testing + 37 spread) ▪ Chronic Disease	6,430/ 17,770 = **36%**

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

						pilot or spread of various initiatives			*because GTNs target age 70 & over*	Nurses – 731(660 in GP practices*, 71 new patients in CD Management Clinic) ▪ aIPCC – 5,496(ESD-209; AURAA-168; GTN-4,889**; AHBT-230) Total = **6,430** Other patients served but not included in above total because of possible double count with abovelisted projects: ▪ Medication Card – 44 patients during trial phase; ▪ Seniors resource List – 278 ▪ Community Partnership – Wellness Connection 48 (Jan- Dec 2013)	
4.	Howe Sound	Pemberton Squamish Whistler	33,458; Pemberton on y=5,118	Planning	In prog-ress	2 in Pemberton IPCC Committee	In progress in Pembert on	Population in Mt. Currie Reserve and Southern Stl'atl'inx	**1,800**	▪ Chronic Disease Nurse in GP practices – 100 from First Nations communities ▪ Telehealth coordinated patient care – 20 ▪ Community partnerships – 66 Total = **166**	186/ 1,800 = 10%

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 2) – June 16, 2013 to September 15, 2013

5.	Vancouver - Downtown Eastside (DTES)	Downtown Eastside Core	61,242	Testing improvements	In place	8 in IPCC Steering Committee and Working Group; 24 involved in the care of 89 patients	In place	Complex marginalized population	89 High ED users of St. Paul's Hospital – visited 10+ during the year; 700 people living in 8 SROs Total = **789**	• Integrated care process - 45 patients • Primary outreach services teams in 8 Single Room Occupancy hotels (started under IHN) -700 patients Total = **745**	745/ 789 = **94%**
6.	Vancouver	All LHAs except DTES	568,663	Spread	In place	GPs of moderate to high risk patients	In place		Complex patients *Note: Although no formal IPCC table, the target population of initiatives is the complex population, an indicator of which is the RUB score. RUB 3, 4 & 5 (moderate, high and very high morbidity =* ***255,001***	• Chronic Disease Nurses in GP practices* - 332 in regular caseload • GP care conference – 159 • Ideal Transition Home – 5,244 patients • aIPCC – 22,213 (ESD-253+351 from PHC; AURAA-129;GTN**-17,398 + 3,080 SPH and 2,819 MSJ; AHBT-183 PHC) • Community partnership – 162 Total = **28,124**	28,124/ 255,001 = **11%**
7.	Sunshine Coast	Sunshine Coast	28,936		In place		In progress				
8.	Bella Coola Valley and Central Coast	Bella Coola Valley & Central Coast	4,290								

* Chronic Disease Nurses in GP practices under the IHN model will be combined with IPCC in the care model that the community decides

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 2) – June 16, 2013 to September 15, 2013

SUMMARY as of September 15, 2013

	Community	Target Population	Patients receiving services	% of target population receiving new services
VCH	Powell River	1,752	775	44%
	North Shore	17,570	4,841	28%
	Richmond	17,770	6,430	36%
	Pemberton	1,800	186	10%
	Van. DTES	789	745	94%
	Vancouver	255,001	28,124	11%
VCH		294,682	41,101	14%

Note: Vancouver's target population are those with moderate, high and very high morbidity (RUB 3, 4 and 5) instead of just high and very morbidity persons (RUB 4 and 5) as was done in the Q1 report.

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 3)

	Community Based Service Delivery Areas **2011/2012**	Collaborative Services Committee priority issues/ <List-may coincide with CSC agendas or IHN Steering Committee Agenda> Below are VCH Local IPCC Steering Committee agenda/issues: Pls. update this column	Describe planned new or redesigned services (and % implemented) < describe **key integration** activities that are being prototyped; **include numbers of other providers** such as case managers, nurse practitioners etc >	Patients as Partners Specific examples of how this service delivery element is being embedded by CBSDA i.e. Patient/community partner on CSC; training etc	Care Planning - Coordinated / Shared Care Plans (key elements or, operational definition ; # shared care plans per GPSC billing fee)
1.	Powell River	▪ Sharing of information between GPs and VCH home health & mental health teams ▪ Shortage of Physicians ▪ Timely communication ▪ Shared care plan – eventually electronic ▪ Building community partnerships	▪ Intake Liaison redesign ▪ Home health service redesign ▪ Connecting pregnancy (Interdisciplinary primary maternity care group visits) ▪ "At-risk" users/presenters to ED ▪ Health Resource Navigator ▪ Community partnerships	▪ Patient representation in IPCC planning such as regional and local IPCC steering committees or working group ▪ Formal orientation of patient representatives before involvement in steering committees/working group ▪ Various ways of capturing patient voice such as patient survey, focus groups and patient journey mapping in improvement initiatives ▪ Involvement in care conferencing and shared care planning	Care planning is done as part of case conferencing between GP and community care providers e.g. case manager, home care nurse. Possible measure is: ▪ Patients in the target population who have a care plan in VCH's PARIS (Primary Access Regional Information System) or paper-based tracking system e.g. in integrated care for high ED users/complex patients in DTES
2.	North Shore	▪ North Shore IPCC Steering Committee had a strategic planning meeting in April 2013 to discuss priorities to be focused on in the upcoming year. The priorities include, Home Health Redesign, High Needs Clinic, First Nations	▪ GP care conferencing ▪ Home and Community Care intake redesign ▪ Chronic Disease Nurse Coordinator Program ▪ Smart phone app on programs and services ▪ High Needs Clinic ▪ First Nations initiatives ▪ Community partnerships	Same as above	Same as above

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

		Health, GP/Primary Care engagement, Public Support/Community engagement			
3.	Richmond	▪ Proactive frailty assessment of all people age 80+ ▪ Improved communication and interaction of among team of care providers ▪ Improved transitions from Acute to primary and community care (pilot project) ▪ Improved patient accessibility to chronic disease management support (Launching of a centrally located clinic)	▪ Standard referral form for all home health services and LTC 1 assessment report to GPs ▪ Screening-Tracking Tool for the frail elderly ▪ Medication management ▪ Senior's Community Resource List and Key Community Agency Partnerships ▪ Chronic Disease Management Clinic ▪ GP care conferencing ▪ Early Supported Discharge ▪ bestPATH ▪ Community partnerships	Same as above	Same as above
4.	Howe Sound - Pemberton	▪ Building on integration practices in current system ▪ Integration between services at Pemberton Health Centre and Mount Currie and Southern Stl'atl'inx Health Centres	▪ Telehealth ▪ Transportation services inventory ▪ Tool to educate staff discharging patients to Pemberton and surrounding areas ▪ Cultural day ▪ Community partnership	Same as above	Same as above
5.	Vancouver - Downtown Eastside (DTES) Core	▪ Downtown Eastside Second Generation Strategy with the vision of integration of care through better coordination of health providers and community agencies	▪ Integrated care process for complex patients ▪ Consultation process to develop the DTEs Second Generation Strategy ▪ Primary Outreach Services ▪ Community partnerships	Same as above	Same as above
6.	Vancouver	▪ Home health redesign ▪ Transitions and care coordination for patients discharged from acute care	▪ Ideal Transition Home initiative ▪ Care conferencing ▪ Community partnerships	Same as above	% of time transition plan transferred with patient (Mod/high risk)

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 3)

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

INTEGRATED PRIMARY AND COMMUNITY CARE

QUARTERLY REPORT (Section 1)

Health Authority : Vancouver Coastal Health	Reporting Period: December 16, 2013 to March 15, 2014
Compiled by: Venie Dettmers/Carol Park	Submitted to MOH: March 22, 2014

Summary of Major Progress and Key Accomplishments Since Last Report

Macro (across HA):

A. Accelerated Integrated Primary and Community Care Initiative (aIPCC)

The projects listed below are being implemented with Accelerated IPCC funding. Separate progress reports are submitted to the Ministry, however, the number of patients served in all aIPCC initiatives are included in Section 2 of this report.

- ***Avoidance of Unnecessary Residential Care and Acute Admissions (AURAA)*** Provides an enhanced home based service to clients who would otherwise be moved to residential care. Care is provided by an interdisciplinary team with the following focus: intensive care management and an enhanced mix of community-based services designed to meet the needs of clients with multiple, complex and interacting chronic diseases and/or social and environmental factors.

- ***Early Supported Discharge*** In collaborative partnership with GPs, an interdisciplinary community reintegration team supports patients with COPD, CHF and stroke through an early discharge from acute care. The team provides short term rehabilitation for up to three months that includes: coordination, education, and provision of self-care management education and support to patients and caregivers to enable them to have knowledge and skills needed to manage their chronic condition.

- ***Frail Seniors Transition*** Expands interdisciplinary teams that address the community transition needs of older adults (70 + years) who present to ED to support prevention of unnecessary acute care admissions, provide seamless transitions to community and primary care resources after an emergency visit, and provide a coordinated approach to manage complex geriatric issues. The teams include geriatric triage/emergency nurses, transitions nurses for follow up support in the community and community-based pharmacists.

- ***Acute Home Based Treatment (AHBT)*** Provides home-based treatment for mental health and addictions clients as an alternative to hospitalization. The AHBT team consists of psychiatrists, clients, families, GPs and nursing staff supported by social workers, counsellors, or rehabilitation professionals as required. This team follows clients and provides intensive short-term treatment for up to 21 days in the clients' home.

- ***Assertive Community Treatment (ACT)*** A client-centered, recovery-oriented mental health service delivery model, the ACT team is mobile and delivers services in community locations to enable clients to continue to live in their community. This service is provided 24 hours a day by a multidisciplinary team, including a GP, with a low client to provider ratio. The expansion of ACT teams is in its early phase.

- ***Care Management/Home Health Redesign*** Aims to redesign VCH Home Health services to align with the provincial care management strategy and integrate teams with primary care in each

community. The components are inter-professional care conferencing between GP and home health team members , telephonic care management, and provider education

B. Other Region-wide Integration Initiatives

- ***First Nations/Aboriginal Initiative –*** The goal is to facilitate the integration of the First Nations and Aboriginal services with the IPCC work. A Regional working group meets regularly and consists of members of the Regional IPCC Team, VCH Aboriginal Team, First Nations Health Authority and the VCH-IPCC Aboriginal/First Nations advisory team which facilitates engagement with First Nations and community members to develop local vision and priorities for IPCC. Highlights during the reporting period were:
  - The dissemination of the inventory/map and analysis of "Availability and Levels of Access to Primary Health Care Services in the 14 First Nations Communities (on-reserve)" to concerned parties internally and externally was continued.
  - An inventory/map of services used by Aboriginal people off-reserve/urban areas in Vancouver, North Shore and Richmond was completed in December 2013 and was presented to VCH Senior Executive Team in December
  - Engagement with First Nations communities was facilitated for the following VCH initiatives: Nurse Practitioner proposals were supported in urban Vancouver for Musqueam and Urban Native Youth Association with Providence Health; and support was provided for the 3 First Nations affected by the transition of services from United Church to VCH in the Central Coast by March 2014. The communities on the Central Coast have agreed to enter into an IPCC model with their local physicians and hospital representatives after April 1st when VCH assumes management of the sites from United Church
  - First Nations Health Directors from Sliammon, Mt Currie & Southern Stlìtlìmx Health Society (4 First Nations), and Squamish & Tsleil-Waututh First Nations are members of local community IPCC steering committees in Powell River, Pemberton and the North Shore, respectively. The First Nations/Aboriginal IPCC has successfully transitioned the work to IPCC leads in these areas and they now operate without the need for support of the First Nations / Aboriginal advisors.
  - Musqueam First Nation in south Vancouver has recently begun formal engagement with the Vancouver Division of Family Practice who is engaging on their Attachment Strategy. Musqueam will host a group of Doctors on-reserve for a "meet and greet" on April 2nd 2014
  - Results of reflections/survey on First Nations/Aboriginal Initiative progress were finalized and provided to IPCC Leads/Evaluation Team for presentation to IPCC Steering Committees, etc. A final report of the First Nations / Aboriginal IPCC initiative has been developed for the period ending March 2014. A presentation of this model was made at the Quality Forum on February 28, 2014 and was well received.

- ***Regional Intensive Complex Patient Care Planning (RICP2) Initiative –*** The goal is to create a regional shared care planning process that ensures a comprehensive approach to caring for patients who frequently visit or use the Emergency Department (ED) for complex and/or chronic care management issues. The focus is on those who visited more than 1 urban ED site 20+ times during the year, and are referred to as "Familiar Faces" (FF). The 6 ED's are: LGH, RH, SPH, MSJH, UBCH, SPH.

- To date, two PDSA's phases have occurred whereby we did trials for developing and coordinating an integrated community based approach to shared care planning for the FF population. A total of 23 Shared Care Plans (SCP), which is 11.5% of the FF population, has been completed and distributed across the 6 ED's involved.
- Breakdown for community teams involved in this work are as follows: 70% Mental Health & Addictions, 20% Primary Care Clinics, 10% Home Health.
- Further work in progress is developing the processes and systems solutions needed to imbed this work into the ED's and community teams.
- The project was recently presented at the BC Quality Forum 2014.

▪ ***Regional IPCC Steering Committee –*** Started discussion and planning the sustainability of IPCC and aIPCC initiatives. The IPCC evaluation plan and update was reviewed and the IPCC Report Card was developed.

Meso and Micro (for specific populations or patient groups; by CBSDA):

1. Powell River

- The following improvement projects are being implemented to achieve integration of care:

1. **Connecting Pregnancy:** Final report completed. A new location has been established to address feedback on logistics through the evaluation. Physician engagement session was held in January to discuss expanding the program to more physicians in the community. Presentation on the project was provided at the BC Quality Forum, February 2014. ***Stage of Project*: *Spread.***

2. **"At Risk" Users/Presenters to the ED** The objective is to better respond to "at-risk" or "high use" patients whose care can be improved by better coordination through the Powell River Hospital Emergency Department. The focus is on:
   - Mental Health (MH) or Addictions Crisis: Evaluation report was completed in January and shared with staff and IPCC-PR Steering Committee. Project was presented at the BC Patient & Safety Quality Council Conference in February 2014. Next steps: need to incorporate primary care feedback into the process and continue to follow health utilization outcomes. ***Stage of Project*: *Sustainment.***

   - **Rapid Process Improvement for Patients with No Family Doctor** ***Stage of Project*: *Spread.*** Evaluation took place including survey of emergency staff and emergency physicians to obtain feedback on process and improvement. Report was completed and shared with staff and IPCC-PR Steering Committee. Next Steps: evaluation showed that a better job needs to be done in informing staff of all the improvements that have been put into place and on-going progress; will start to make connections with the Home Health Redesign process to better coordinate with patients presenting to the Emergency department. For patients with 5+ visits, the ED patient care coordinator is creating a care plan for the patients that includes primary care and patient feedback.

3. **Health Resource Navigator –** The objective is to assist physicians in identifying available health and social support services and linking patients to these services. ***Stage of Project: Testing***. Conducting the final evaluation in March that will help inform feasibility decisions

that will occur in April May 2014.

4. **Integrated Practice Support Initiative (IPSI) Powell River Initiative** As planned, the Practice Support Committee was established and includes the Health Authority. Project was presented at the BC Quality Forum in February 2014.

5. **Shared Care Initiatives** The objective is to ensure that primary care is delivered and managed by family physicians with ready access to specialist physician advice and support. The focus in Powell River is palliative care. ***Stage of project: Planning.*** Community survey regarding End-of-Life care is in progress.

6**. Nurse Practitioners –**

a) NP at Tla'amin Nation: (NP for BC) This is a partnership between the Health Authority and the Tla'amin Nation. NP hired end of January. Health Authority currently supporting the NP with primary care engagement. NP is conducting community engagement and is working closely with the elders to understand the needs of the Nation. Clinic has been set up at the Tla'amin Health Centre with intent to officially open on March 31st, 2014. NP clinic will be adopting the OSCAR electronic medical record system.

b) Community NP: (NP for BC) proposal has been approved. DoFP is been working closely with the Health Authority to determine recruitment process and compensation package.

c) Primary Care Health Clinic NP: was initiated to support the lack of physicians in the community and started in 2013. NP provides care for complex patients in residential care. With the departure of two family physicians in Jan 2013 there was an increasing demand of patients with no family doctors. As a result, local leadership team opened a Primary Care Clinic in Ambulatory Care for 4 hours per week. Patients have no family doctor and require longitudinal care. With an increasing demand for care, there is the need for another clinic day. Analysis of NP processes and patient profile is underway to understand the need in the community.

7. **Community partnership** projects funded in 2013/14 and status is as follows:

- ***Powell River Employment Program Society*** provides two programs to the community.
  - *Humble & Hearty Workshop*
    Purpose of the program: Deliver 18 participatory workshops annually to show low-income clients with chronic health conditions how to cook healthy meals using low-cost ingredients.
  - *Monday Brunch*
    Purpose of the program: Increase access to meals for people with chronic health problems and increase access to public health professionals and other educational and social supports.

A client satisfaction survey was conducted in January which shows 70% are satisfied.

CRC Patron Survey Results-02-24-14-v1

- ***Building Recovery of Individual Dreams & Goals through Education (BRIDGES) (BC Schizophrenia Society):***
  Purpose of the program*:* help people understand and recover from mental illness. A course taught by consumers for consumers to empower people with tools that will help them in their journey to recovery. Meetings are held the third Monday of each month from 7:00 to 8:30 pm, in the meeting room on the third floor of the hospital.

- ***Promoting Community Wellness (The Source Club Society)***
  Purpose of the program: Promoting community wellness and providing people living with mental illness with social and recreational activities, opportunities to engage in health practice.

- Survey of Community Projects as part of ongoing evaluation, a survey of community partners was conducted to determine successes and areas of improvement.
  Survey results are attached below.

Community Partners Survey Results.doc

2. North Shore

- North Shore IPCC Steering Committee:
  - All North Shore strategic priorities are standing items discussed at each meeting. Strategic priorities include Home Health Redesign, Aboriginal Health, GP and community engagement, and the High Needs Clinic.

- The following improvements are being implemented to achieve integration of care:

1. **GP Care Conferencing** Care conferencing in person or over the phone between Home and Community Care (HCC) staff was rolled out beginning of October 2012. This rollout builds on the pilot testing of care conferencing with case managers in late winter/spring 2012. ***Stage of Projec***t: ***Spread***. Process has been rolled out to all HCC clinicians. Workflow has been established and clerical support implemented to arrange conferences for clinicians. To date, 200 clients have had care conferences conducted on their case. In total 84 GPs have engaged in care conferencing with 44 HCC staff.

2. **Home and Community Care Intake Redesign** In response to a Lean analysis recommendation, an intake clerk position was created to reduce the amount of non-clinical administrative work such as faxing, collecting demographic information by intake nurses, and having 'live' clerical support answering calls. As of December 2012, a new workflow has been established in order to reduce the bottleneck of referrals and increase feedback and communication to GPs on the status of the referral to Home & Community Care. ***Stage of Project: Sustainment***.

3. **Chronic Disease Nurse Coordinator Program** The objective is to support family physicians in providing comprehensive, guideline-based care to their complex patients with two or more chronic conditions. A key change idea for this program is that the CDN Coordinator is housed in a central location at a Community Health Centre rather than embedded in a Family Physician's private practice. ***Stage of Project: Sustainment***. To date, a total of 143 clients from 37 different GPs have been referred to the program. Of the referring GPs, 14 (37.8%) have referred more than 1 of their patients to the program. There are 113 currently active clients in the program (and 30 clients who have been discharged). Additional presentations to GPs and other VCH programs continue in order to increase program awareness and referrals.

4. **Smart Phone App** The objective is to make information about programs and services that support the health and wellness of the North Shore population accessible to physicians and their MOAs, as well as other care providers. In addition to the iPhone App, a web-based version (server app) has also been developed (the latter intended for use by those without an iPhone). ***Stage of Project: Final stages of testing.*** Service agreement with third-party hosting provider has been signed by all three parties (VCH, Division of Family Practice and Canadian Web Hosting). Developers have deployed server app and updated the iPhone app to meet iOS7 requirements. iPhone and server app being tested in advance of final submission to the Apple App Store for their review. A communication plan will be developed with initial focus of rollout/education on how to access and use the app to VCH staff and members of the Division of Family Practice.

5. **High Needs Clinic** (*HealthConnection* Clinic) The objective is to provide supportive, low-barrier primary care services for North Shore residents with complex needs and no regular access to a family doctor or nurse practitioner. The clinic is a partnership between North Shore Division of Family Practice and VCH with additional support provided by the Physician Information Technology Office and the Practice Support Program. The clinic is currently open to see clients Monday to Friday between 9AM and 12noon. The clinical team includes GPs, NPs, CDN and an MOA. The Canadian Mental Health Association, Lookout Society and Hollyburn Family Services have outreach workers and social work practicum students scheduled to work out of the clinic to provide non-medical supports to clients. North Shore Neighborhood House is another community partner that can support clients of the clinic. ***Stage of Project: Implementation***. The Steering Committee continued to meet to refine processes, workflows and clinic forms. On April 1, 2014, a new NP on the North Shore will join the clinical team. Funding to support operations for a 2nd year has been secured. A six-month check-in was completed and evaluation results of the clinic indicate: clients love the clinic and the services they receive from it; staff are pleased with the collaborative atmosphere at the clinic; and the clinic is starting to see a decrease in acute care utilization for clients. To date, 669 visits to the clinic have been made by 171 were new client visits. Preliminary evaluation outcomes and an overview of the unique aspects of the clinic model and funding were presented at the Quality Forum in 2014. A copy of the poster presentation is attached.

G:\HealthConnection Clinic (Dept VCH)\Eva

6. **Integrated Practice Support Initiative (IPSI) North Shore Initiative** The objective is to strengthen the delivery of quality practice support by aligning PSP and PITO practice support services. The IPSI project has the go ahead to continue the project until March 2014.

7. **Shared Care Initiatives** The objective is to ensure that primary care is delivered and managed by family physicians with ready access to specialist physician advice and support. Areas of focus in the North Shore are orthopaedics, mental health and oncology.
   Orthopaedics ***Stage of project: Testing and scaling up*** for the following projects: advice line, centralized referral system, screening clinic, referral acknowledgment and consult template and sharing of care. And ***Planning stage*** for accurate identification of family physician upon acute admission.
   Mental health ***Stage of project: Testing and scaling up*** for one time consult followed by group visits. And ***Innovation development*** for transitions into and out of acute and referral processes to psychiatry.
   Oncology ***Stage of project: Innovation development*** for rapid access to breast cancer care and specialized role of a family physician in oncology.

8. **Community partnership** projects funded in 2013/14 and their status in Q3 (October 1-December 31, 2013) are the following:
   - ***Counseling Service for Patients with Complex Health Issues (Canadian Mental Health Association)*** Individual and group counselling for individuals experiencing mild to moderate depression and chronic illness. Number of referrals received during the quarter: 23. Patients seen during the quarter: 13. An evaluation of the IPCC Counselling Program (attached below) shows promising results from client and provider feedback as well as from client health outcomes.

     Final Report IPCC Counselling Program F
   - ***Peer Support for Health and Wellness (North Shore Neighbourhood House) –*** offers one-on-one emotional support, guidance regarding life changes and challenges, as well as provide resource information. Referral INTAKES - 8 new clients from health services (case workers, SW at LGH, crisis services etc); 18 ongoing clients. Nine new volunteers will start training which includes Elder Abuse and Neglect, Dementia and Alzheimers, Advance Care Planning and NIDUS (Representation Agreements), Crisis Services presentation, Transportation for seniors access, and Better at Home requirements.
   - ***North Shore Keep Well (North Shore Keep Well Society) –*** an exercise and wellness program for mobile seniors to encourage and help older adults to keep well by leading active and independent lives. The program includes one hour of exercise followed by blood pressure checks and health coaching, massage, speakers and social times. Total attendees during the quarter in 7 sites: 2717.
   - ***Golden Circle (North Shore Neighbourhood House)*** offers wellness and leisure education to frail seniors who may have challenges accessing programs. It includes out-trips, healthy snacks/social time, education speakers, brain and memory games, chair exercises and other recreational activities. Total number of participants for the quarter: 296
   - ***First Link*** a first response strategy for people newly diagnosed with dementia and their families. It includes proactive outreach, information and connections, and planned

follow-up. In order to ensure that services appropriate to people with early symptoms of dementia are available in the community, Minds in Motion™ and Shaping the Journey: living with dementia™ are implemented alongside First Link®.
Status in the North Shore and Sunshine Coast is as follows:

- Number of referrals received during the quarter 64 with majority coming from GP/primary care and self-referrals.
- Number of active cases to date - 89
- Number of Shaping the Journey participants 0
- Number of Minds in Motion Participants 33
- Outreach to health professionals/Number of meetings and presentations - 10

- ***Volunteer Drivers –*** Run by North Shore Neighbourhood House, the medical rides pilot project uses NSNH trained peer support volunteers who donate their time and personal vehicle to transport and accompany complex clients to and from their medical appointments and treatments. 45 ride requests this quarter. Thirty of the ride requests were successfully completed. Fifteen ride requests were not completed due to cancellations, inability to find a volunteer driver etc.

3. Richmond

- Evaluation of the effectiveness of the Richmond IPCC Steering Committee was completed and shared with at the IPCC meeting. The results were positive and overall members felt collaborative approaches effective in moving integration forward although agree that the process has been slow.

- Continued to strengthen linkage and partnership with the Division of Family Practice
  - Regular updates re the GP for Me attachment initiatives at the IPCC table.

- Ongoing work /partnership with the Practice Support Program to leverage integration work
  - Information re GP Care Conferencing initiative shared at the End of Life Module 3rd session in the fall. 27 Richmond Family Physicians attended. Copies of the brochure re the Chronic Disease Management Clinic were also made available.
  - PSP Lead (during December) will be delivering Seniors Resource & Support Folder to those 38 GP Practices who previously have indicated an interest in receiving a copy.
  - Continued to work closely together to look for opportunities to highlight integration initiatives.

- The following improvements are being implemented to achieve integration of care:

1. **Standard Referral Form and Long Term Care 1 (LTC1) Report** The objective is to streamline the referral process from GP to HCC and feedback to GPs. The HCC referral form has been redesigned and a feedback loop confirming services to the GP is part of SOP. A LTC 1 Report will be faxed to GPs regarding new clients referred to Case Management. ***Stage of Project***: ***Sustainment*** (HH referral form spread to all the 130 GPs*)*. Tracking results indicate referrals forms are being completed appropriately with very little error or misses. Report regarding key insights and experience of the process is being developed.

2. **Screening Tool for Frail Elderly** This one-page screener was developed with Family Physicians to use in their practice to actively case find frail elderly patients who could benefit from referral

to Case Management (CM) service and to proactively identify clients who are not eligible for CM, but are at risk and may benefit from social supports and services available in the community. ***Stage of Project: Spread***. The tracking of the screener tool indicates that as of March 2014, 45 tools were completed.

The challenge is how to continue raising awareness regarding the availability and usefulness of this tool to Richmond Family Physicians. To leverage the sessions held by PSP event - End of Life.

3. **Medication Management** The objective is to create an accurate patient medication list to improve communication and interaction within the inter-professional team resulting in coordinated care, awareness of patient status and reducing duplication of work and frustration. ***Stage of Project*: Completion of the pilot phase.** An evaluation was carried out to determine if the creation of an accurate patient medication card (BC Patient Safety and Quality Council medication card) improved communication and interaction within the interprofessional team resulting in coordinated care, awareness of patient status and reduction in duplication of work and frustration. There are however, limitations to the evaluation of this initiative. This includes: only 4 GP practices responded to the post survey; no patients completed the post survey and the feedback from the Home Health nurses, although valuable was provided through an informal process.

4. **Senior's Community Resource List and Key Community Agency Partnerships** The objective is to develop one resource list for GPs and other health care providers to use in their practice that includes non medical supports and services available in Richmond for seniors.
Stage of Project: Spread. This resource folder is now complete and includes a Mental Health section (based on the feedback from the participants during the trial phase). The folder is being distributed to VCH clinicians and GP Practices. A storyboard poster was presented at the BC Patient Safety and Quality2014 Forum.

Storyboard SENIORS RESOURCE LIST BCP

5. **Chronic Disease Management Clinic** A Chronic Disease Management clinic was established at 8100 Granville with the objective to engage GPs in referring patients with chronic conditions for comprehensive guideline-based care to a centrally located clinic. Chronic Disease (CD) Nurses (2 of the 5 nurses are able to speak Chinese) will support patients to manage their health conditions. A key change is that CD Nurses can provide support to GPs who DO NOT have a nurse attached to their practices. ***Stage of Pilot Project***: 13 GP practices have referred. This includes 6 GP Practices who have a predominately large Chinese speaking population. As of March 2014, 93 patients have been seen.

   An evaluation was carried out in January 2014. The evaluation is currently being analyzed and will be shared with key stakeholders, including at the IPCC Steering Committee.

6. **GP Care Conferencing –** GP Care conferencing initiative was launched in February 2013. The goal of the conference is to improve communication between GPs and HH clinicians around complex patients in order to better meet their health needs. The conferences are scheduled in advance

with the GP, thereby ensuring that all participants in the conference have dedicated time to focus on the patient's needs. A regional project team working group has been established to help facilitate the implementation of GP Care Conferencing in regular HH practice at each of the CoC. ***Stage of Project***: ***Spread***. To date, 173 clients have had care conferences held on their case.

7. **bestPath –** (Person-centred, Appropriate, Timely Healthcare) has recently been launched by VCH-Richmond. bestPATH is a partnership between Richmond acute teams, community teams and primary care to improve health outcomes as the patient moves between multiple providers and acute to community and primary care. ***Stage of Project***: ***Implementation***. Sessions were held to bring together Family Physicians, Home Health and Acute care staff around patient flow/transition to:
   - Gain a better understanding re the learnings from bestPATH and other key pilot projects
   - Provide an opportunity for input from DoFP/Family Physicians
   - Jointly identify priorities/or "always events" with the goal of improving patient care and flow
   - Identify next steps

   6 Family Physicians attended. One of the outcomes of the session was that "10 Always events" were determined. The next steps are to look at the "how" or the implementation and development of the action plans.

8. **ED-GP Just in Time Notification Trial** Small trial with 3 Primary Care (PC) Physicians and ED Physician is being piloted re notifying the PC physicians participating should their patients be admitted to ED. The PC physicians have been asked to select their preference of communication: email, text or telephone. The logistics are being worked out now; the intent is to expand the pilot to 7 more physicians.
   See attachment for more details.

   
   ED GP Just in Time Notification - one pag

9. **Shared Care Initiatives** The objective is to ensure that primary care is delivered and managed by family physicians with ready access to specialist physician advice and support. Areas of focus in Richmond are orthopaedics and rheumatology. ***Stage of project: Innovation development*** for referral processes. The IPCC Integration lead is part of this steering committee to provide a VCH perspective as appropriate.

10. **Community partnership** projects supported in 2013/14 and their status in Q1 (July-September) are the following:
    - ***Wellness Connections Program*** - a transitional therapeutic recreation bridging program that enables frail isolated seniors and people with multiple chronic conditions to identify and master the skills for community recreation participation and community inclusion.
      113 clients participated in the Wellness Connections Program to date. A summary of the report/outcomes is listed below indicating positive improvements regarding physical status indicators, socialization and mood levels.

Richmond Wellness Connection 2013 Sur

- ***First Link*** a first response strategy for people newly diagnosed with dementia and their families. It includes proactive outreach, information and connections, and planned follow-up. In order to ensure that services appropriate to people with early symptoms of dementia are available in the community, Minds in Motion™ and Shaping the Journey: living with dementia™ are implemented alongside First Link®. Status in Richmond/South Delta is as follows:
  - Number of referrals received during the quarter 37 with majority coming from assessment clinic/specialist.
  - Number of active cases to date 551
  - Number of Shaping the Journey participants 0
  - Number of Getting to Know Dementia participants 4
  - Number of Minds in Motion participants 54
  - Number of participants in Caregiver Series (Cantonese) - 28
  - Outreach to health professionals/Number of meetings and presentations) - 0

4. Pemberton and Squamish in Sea-to-Sky

A. The Pemberton IPCC Committee continued to provide support and direction to the identified opportunities for improvement:

- Continued working with First Nation in Mt. Currie to find opportunities to improve integration of services with VCH.
- A strategic planning day was held to develop priority areas for 2014/2015.
- **Telehealth** The objective is to improve communication between healthcare providers and clients living in rural communities. E20 units have been installed in communities and have been used 20 times in Pemberton to coordinate patient care. ***Stage of Project: Pilot.*** 60 calls have take place in the last quarter. Units were not operation for 4 weeks due to weather and holiday time. The units are currently being used to confirm treatment plans, received medical education and the use of the units to provide triage advice there have been avoided ER trips.
- **Transportation services** The inventory has been completed. It includes a list of what transportation is available within the community and the services available to Vancouver. Also developed was an inventory of funding sources available to access transportation needs. Next step is to align with the Better at Home work.
- ***Discharge Information form*** The objective is to better support hospital discharges to Pemberton. The form contains information about discharging a patient home to a rural community. Rural communities have specific challenges with transportation, available services and access to specialized medication and equipment. ***Stage of project: Spread***. The form is being used with local hospital staff.
- ***Nurse Practitioners*** have been in practice for the last 3 months. Orientation has been provided by other the family physicians and Vancouver Coastal health. Nurse practitioner is currently seeing between 16-20 per day. Next steps: provide orientation to the first nation communities and begin to provide services early summer.
- **Shared Care Initiatives** The objective is to ensure that primary care is delivered and managed by family physicians with ready access to specialist physician advice and support. Area of focus in Squamish is oncology. ***Stage of project: Innovation development*** for improved processes for

the delivery of chemotherapy within the community; and improved communication and continuity of care between the Squamish physicians and Lions Gate Hospital.

- **Community partnership** project supported in 2013/14 and their status in Q1 (April-June) are the following:
    - ***Bowling for Life*** an opportunity for seniors of Pemberton and elders in Mt. Currie to come together for an afternoon of Wii bowling and lunch. Average number of participants: 66. Evaluation: Informal Feedback from clients indicates a high degree of satisfaction with the program.
    - ***Exercise 4 Brain & Neuro Health in Squamish*** - Program was launched in September 2013. The aim is to provide exercise and support to patients with neurological conditions such as MS, Parkinson's, and stroke. Another evaluation will be made available after the winter session.

B. Squamish Integration Table: First Nations Heath Director, local VCH leadership and local Division of Family Practice leadership have been meeting.

5. Downtown Eastside (DTES) Vancouver

- **Integrated care process for the high ED users –** The objective is to improve care coordination and proactive community-based care planning through care conferencing and care planning. ***Stage of Project: Sustainment***. Best practices are being incorporated into everyday work and complex clients will be the target client group. Evaluation results including reduction in ED visits and hospital admissions are summarized in attached presentation at the BC Quality Forum.

Shared Care Planning Final -BC Qu

- **Primary Outreach Services Teams** The goal is to provide primary care on site for people who have difficulty accessing care. Teams continued to hold clinics in single occupancy hotels (SROs) and shelters providing mental health, addiction and primary care. They also provide ongoing case management and health care support to 700 clients. ***Stage of Project: Standard Practice.***

- **Community partnerships** Tenancy supports were funded through the non-profit organizations operating the SRO: Raincity Housing and Support Society, and Portland Hotel Society Community Services.

6. Vancouver

Vancouver Community of Care has initiated projects that facilitate integration of care. They include:

- **Ideal Transition Home (ITH)** The goal is to improve the patient and family experience and provide quality outcomes for patients discharged from VGH and Providence. The interventions are:

    Within 48 hours of admission:

    - *Readmission Risk assessment* score initiated (early identification of patients at moderate to high risk for readmission)
    - *Readmission Risk mitigation checklist* initiated (standardized interventions)
    - *Hospitalization notice* faxed to GP in community
    - *Referral* sent to community for known clients and for assessment for new clients

And upon discharge:

- *My Discharge Plan is* completed and given to patient/family and faxed to community and community GP (discharge notification fax).
- *High risk patients* - Follow up GP appointment made prior to discharge for 48 hours post discharge.
- *Moderate risk patients* Follow up GP appointment made prior to discharge for 3-5 days post discharge and a follow up phone call to patient/family by Care Management Leader 48 hrs post discharge.

Stage of Project at VGH: Spread phase. The estimated number of patients that have been discharged through the ITH process since the implementation in February 2012 to February 27, 2014 was 6,579 of which: High Risk = 2,600 and Moderate Risk = 3,979.

Stage of Project at Providence: Testing/prototype development of the frontend elements of the Ideal transition home care process.

- **Care Conferencing –** The objective is to better coordinate care between GP and home health staff. ***Stage of Project: Spread.*** With the renewed emphasis on GP Care Conferencing, as part of the Home Health Redesign the initiative, a Vancouver GP Care Conferencing working group has been established. This group is made up front line clinicians, family physicians, and managers, and will serve to guide the roll out of GP Care Conferencing in to all of the Vancouver CHCs. The Working Group is currently choosing priority populations to start care conferencing about and working on the education elements that are necessary for staff. To date, 156 clients had a care conference held on their case.

- **Shared Care Initiatives** The objective is to ensure that primary care is delivered and managed by family physicians with ready access to specialist physician advice and support. Area of focus in Vancouver is internal medicine. ***Stage of Project: Innovation development*** for improved communication with family physicians upon patient's admission; invitation to family physician to take part in the patient's care while they are admitted; and improved involvement with the family physician in the creation of the care plan; notification of discharge to the family physician; and appointment with the family physician within 72 hours of discharge.

- **Community partnerships** supported in 2013/14 and their status in the previous quarter (October-December 2013) are as follows:
  - ***Development of COPD-related Educational Materials with an Appropriate Assessment of Health Literacy and Ethnic Needs (BC Lung Association*) –** The objective is develop, based on inputs from patients and front line health workers, educational materials in English, Mandarin, Cantonese, Farsi, Korean and Filipino.

    Developed were 56 short and long video clips for inhaler techniques (MDI, Diskus, Turbuhaler, Handihaler, and Breezhaler) and how to manage COPD at home. Materials were tested and evaluated with Filipino and Mandarin COPD patients and health professionals to test the applicability and relevance of the videos and written materials. E valuation of materials will continue with COPD patients and healthcare professionals in other target languages before finalizing the materials for mass production stage.

- **Strengthening Community-based Resources for Families Experiencing Perinatal Depression and Anxiety and Their Health Care Providers (Pacific Post Partum Support Society (PPPSS)) –** Information gathered and recordings from patients and healthcare professionals and community support workers will be used to among others: Create new culturally appropriate content for the Chinese, Farsi, Punjabi, and Spanish language informational brochures (Farsi and Spanish brochures do not currently exist); update PPPSS training materials for community-based health care professionals; and make the PPPSS website more engaging, interactive, and culturally appropriate.

  Audio and video clip library created and staff trained in use in ongoing. Also in progress are: development of new English language content is being developed for the website; translation of brochure.

- **Access For All – Supported Health & Wellness Program (Langara Family YMCA) –** The objective is to provide VCH clients with opportunities and support to improve physical activity and develop exercise habits and healthy lifestyle behaviours. This project builds off of the current and successful Access for All model while incorporating a consistent, detailed and thorough support and follow-up component.

  While 27 referrals have been received for Access for All, referrals for supported health and wellness have to be made. Challenges are being addressed.

- ***First Link (Alzheimer's Society)*** a first response strategy for people newly diagnosed with dementia and their families. It includes proactive outreach, information and connections, and planned follow-up. In order to ensure that services appropriate to people with early symptoms of dementia are available in the community, Minds in Motion™ and Shaping the Journey: living with dementia™ are implemented alongside First Link®.
  - Number of referrals received during the quarter - 54 with majority coming from assessment clinic/specialist.
  - Number of active cases to date 261
  - Number of Minds in Motion Participants 58 in 4 areas: Kitsilano, West End, Marpole-Oakridge Community Centre and Hillcrest Centre.
  - Number of participants in Caregiver Series (Cantonese only) 0
  - Outreach to health professionals/Number of meetings and presentations) 4

- ***Education Programs for People Living with Arthritis-Expansion in Vancouver (The Arthritis Society BC & Yukon Division) -*** The purpose is to help patients to learn to live well with arthritis and for health providers to learn about this disease in order to better understand this chronic disease and how to work more effectively with patients. The Arthritis Society will offer a four part education program that includes Arthritis Self-Management Programs and Chronic Pain Management Workshops plus offer a targeted ten workshop series designed to provide information and support in a small group setting.

  Number of participants in Chronic Pain Management Workshops 58
  Number of participants in Arthritis Self-Management Program 19
  Number of participants in Symptom Management Workshop - 112

QUARTERLY REPORT (Section 1)

Key Issues, Dependencies and Mitigation Strategies:	
Issues/dependencies/barriers across communities: ▪ Sustainment of improvements after end of IPCC funding in March 2015	Mitigation Strategy: ▪ Sustainability options identified and discussed ▪ Presentations made to senior leadership on status of initiatives and their financial viability

Successes and Lessons Learned:

- Local working groups bring stakeholders together to address issues, plan improvements and plan sustainability.
- Staff forums are helpful in providing updates to initiatives

PRESENTATIONS

- ***BC Quality Forum 2014 February 27-28, 2014 -*** *Thirteen presentations and posters pertain to IPCC work. These are listed in the attachment below.*

BC Quality Forum
Abstracts Accepted 1

QUARTERLY REPORT (Section 2) – December 16, 2013 to March 15, 2014

	Community Based Service Delivery Areas	Communities included in CBSDA	Total Population of CBSDA	Version #[1] /stage planning & implementation	Division *-In place -In Progress -Not started*	# Family Physicians engaged (re ated to vers on/ terat on)	CSC *-In place -In Progress -Not started*	Target Population(s) *Name (i.e. frail elderly – home health) & Case definition*	# People in the Target Population *(estimate based on case definition - denominator)*	# Patients receiving new or redesigned services *(cumulative # of unique patients)*	% Reach[2]
1.	Powell River	Powell River	19,733	Testing improve ments	In place	2 in Steering Committee & 21 in various initiatives	In place	Very High & High morbidity (esp. w/ cardio-vascular disease or Mental Health & Substance Use problems)	1,722 + 30 from Connecting Pregnancy = **1,752**	▪ Connecting Pregnancy - 30 ▪ Resource Navigator - 16 ▪ At risk users/ presenters to ED - 286 ▪ Intake redesign - 35 ▪ Community partnership projects with patients in target population – 408 Total = **775** Other patients served but not included in above total: ▪ Community partnership projects for vulnerable patients – 2411	775/ 1,752 = **44%**

* Chronic Disease Nurses in GP practices under the IHN model will be combined with IPCC in the care model that the community decides

**Counted the higher number between GTN In Emergency Assessment and Telephone Follow-up

[1] *Version # indicates progress using incremental improvements; if your HA uses a stages of implementation framework, please indicate that status/iteration)*

[2] *Reach = number of patients receiving services (cumulative count)/ number of patients in target population (actual as per case definition, or estimate)*

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 2) – December 16, 2013 to March 15, 2014

2.	North Shore	North Vancouver & West Vancouver	186,776	Testing improvements and spread	In place	3 in Steering Committee; & 73 in various initiatives	In place	Chronic, co-morbid/complex medical care needs	**17,570** (includes 2,200 Home Health clients, 15,220 high needs clients and clients of chronic disease nurses/coordinator)	▪ GP care conferencing – 200 patients; ▪ Chronic Disease Nurse* in GP practices – 837 in regular caseload ▪ High Needs (HealthConnection) Clinic – 171 (100 of these clients have made 2 or more visits to the clinic to date) ▪ aIPCC projects – 2,737 (ESD-349;AURAA-180; GTN-1,782; AHBT-426) ▪ Community partnership projects with patients in target population – 120 ▪ Chronic disease nurse coordinator – 143 **Total = 4,208** Other patients served but not included in above total: ▪ Community partnership projects – 3,043 (for mobile and active seniors who not likely to be Home Health clients or high needs patients)	4,208/ 17,570 = **24%**

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 2) – December 16, 2013 to March 15, 2014

3.	Richmond	Richmond	189,027	Testing improvements & Spread	In place	17 in Steering Committee and working groups; 130 in the pilot or spread of various initiatives	In place	Frail elderly: age 80+ and 70-79 with Alzheimer/ dementia	7,178 (age 80 & over) + 10,592 (age 70-79) = **17,770** *Note: Age 70-79 was added because GTNs target age 70 & over*	▪ GP Care conferencing –173 patients ▪ Screening-Tracking Tool – 57 (20 testing + 37 spread) ▪ Chronic Disease Nurses – 731(660 in GP practices*, 93 patients in CD Management Clinic) ▪ aIPCC – 4,611(ESD-307; AURAA-195; GTN-3,849; AHBT-260) **Total = 5,594** Other patients served but not included in above total because of possible double count with abovelisted projects: ▪ Medication Card – 44 patients during trial phase; ▪ Seniors resource List – 278 ▪ Community Partnership – Wellness Connection 48 (Jan- Dec 2013)	5,594/ 17,770 **= 31%**
4.	Howe Sound	Pemberton Squamish Whistler	33,458; Pemberton on y=5,118	Planning	In prog-ress	2 in Pemberton IPCC Committee	In progress in Pembert on	Population in Mt. Currie Reserve and Southern Stl'atl'inx	**1,800**	▪ Chronic Disease Nurse in GP practices – 100 from First Nations communities ▪ Telehealth coordinated patient care – 20	186/ 1,800 = **10%**

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 2) – December 16, 2013 to March 15, 2014

										▪ Community partnerships – 66 Total = **166**	
5.	Vancouver - Downtown Eastside (DTES)	Downtown Eastside Core	61,242	Testing improvements	In place	8 in IPCC Steering Committee and Working Group; 24 involved in the care of 89 patients	In place	Complex marginalized population	89 High ED users of St. Paul's Hospital – visited 10+ during the year; 700 people living in 8 SROs Total = **789**	• Integrated care process - 45 patients • Primary outreach services teams in 8 Single Room Occupancy hotels (started under IHN) -700 patients Total = **745**	745/ 789 = **94%**
6.	Vancouver	All LHAs except DTES	568,663	Spread	In place	GPs of moderate to high risk patients	In place		Complex patients *Note: Although no formal IPCC table, the target population of initiatives is the complex population, an indicator of which is the RUB score. RUB 3, 4 & 5 (moderate, high and very high morbidity =* ***255,001***	• Chronic Disease Nurses in GP practices* - 332 in regular caseload • GP care conference – 156 • Ideal Transition Home – 6,579 patients • aIPCC – 13,424 (ESD-294+401 from PHC; AURAA-161;GTN-8,307 + 2,000 SPH and 2,016 MSJ; AHBT-245 PHC) • Community partnership – 450 **Total = 20,941**	20,941 /255,001 = **8%**
7.	Sunshine Coast	Sunshine Coast	28,936		In place		In progress				
8.	Bella Coola Valley and Central Coast	Bella Coola Valley & Central	4,290								

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

		Coast									

SUMMARY as of March 15, 2014

	Community	Target Population	Patients receiving services	% of target population receiving new services
VCH	Powell River	1,752	775	44%
	North Shore	17,570	4,208	24%
	Richmond	17,770	5,594	31%
	Pemberton	1,800	186	10%
	Van. DTES	789	745	94%
	Vancouver	255,001	20,941	8%
VCH		294,682	32,427	11%

Note: Vancouver's target population are those with moderate, high and very high morbidity (RUB 3, 4 and 5) instead of just high and very morbidity persons (RUB 4 and 5) as was done in the Q1 report.

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 3)

	Community Based Service Delivery Areas **2011/2012**	Collaborative Services Committee priority issues/ <List-may coincide with CSC agendas or IHN Steering Committee Agenda> Below are VCH Local IPCC Steering Committee agenda/issues: Pls. update this column	Describe planned new or redesigned services (and % implemented) < describe **key integration** activities that are being prototyped; **include numbers of other providers** such as case managers, nurse practitioners etc >	Patients as Partners Specific examples of how this service delivery element is being embedded by CBSDA i.e. Patient/community partner on CSC; training etc	Care Planning - Coordinated / Shared Care Plans (key elements or, operational definition ; # shared care plans per GPSC billing fee)
1.	Powell River	▪ Sharing of information between GPs and VCH home health & mental health teams ▪ Shortage of Physicians ▪ Timely communication ▪ Shared care plan – eventually electronic ▪ Building community partnerships	▪ Intake Liaison redesign ▪ Home health service redesign ▪ Connecting pregnancy (Interdisciplinary primary maternity care group visits) ▪ "At-risk" users/presenters to ED ▪ Health Resource Navigator ▪ Nurse Practitioners ▪ Community partnerships	▪ Patient representation in IPCC planning such as regional and local IPCC steering committees or working group ▪ Formal orientation of patient representatives before involvement in steering committees/working group ▪ Various ways of capturing patient voice such as patient survey, focus groups and patient journey mapping in improvement initiatives ▪ Involvement in care conferencing and shared care planning	Care planning is done as part of case conferencing between GP and community care providers e.g. case manager, home care nurse. Possible measure is: ▪ Patients in the target population who have a care plan in VCH's PARIS (Primary Access Regional Information System) or paper-based tracking system e.g. in integrated care for high ED users/complex patients in DTES
2.	North Shore	▪ North Shore IPCC Steering Committee had a strategic planning meeting in April 2013 to discuss priorities to be focused on in the upcoming year. The priorities include, Home Health Redesign, High Needs Clinic, First Nations	▪ GP care conferencing ▪ Home and Community Care intake redesign ▪ Chronic Disease Nurse Coordinator Program ▪ Smart phone app on programs and services ▪ High Needs Clinic ▪ Community partnerships	Same as above	Same as above

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

		Health, GP/Primary Care engagement, Public Support/Community engagement			
3.	Richmond	▪ Proactive frailty assessment of all people age 80+ ▪ Improved communication and interaction of among team of care providers ▪ Improved transitions from Acute to primary and community care (pilot project) ▪ Improved patient accessibility to chronic disease management support (Launching of a centrally located clinic)	▪ Standard referral form for all home health services and LTC 1 assessment report to GPs ▪ Screening-Tracking Tool for the frail elderly ▪ Medication management ▪ Senior's Community Resource List and Key Community Agency Partnerships ▪ Chronic Disease Management Clinic ▪ GP care conferencing ▪ bestPATH ▪ Community partnerships	Same as above	Same as above
4.	Howe Sound - Pemberton	▪ Building on integration practices in current system ▪ Integration between services at Pemberton Health Centre and Mount Currie and Southern Stl'atl'inx Health Centres	▪ Telehealth ▪ Transportation services inventory ▪ Discharge information form ▪ Nurse Practitioner ▪ Community partnerships	Same as above	Same as above
5.	Vancouver - Downtown Eastside (DTES) Core	▪ Downtown Eastside Second Generation Strategy's vision of integration of care through better coordination of health providers and community agencies	▪ Care conferencing and shared care planning for complex patients ▪ Primary Outreach Services ▪ Community partnerships	Same as above	Same as above
6.	Vancouver	▪ Home health redesign ▪ Transitions and care coordination for patients discharged from acute care	▪ Ideal Transition Home initiative ▪ Care conferencing ▪ Community partnerships	Same as above	% of time transition plan transferred with patient (Mod/high risk)

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT (Section 3)

Legend:	Comp ete	On Track	Some Concern	Major Concern	Not Started	Tab e Head ngs

QUARTERLY REPORT - INTEGRATED PRIMARY AND COMMUNITY CARE

Health Authority: Vancouver Coastal Health	Reporting Period: March 16 to June 30, 2014
Compiled by: Venie Dettmers	Submitted to MOH: July 8, 2014

# of CBSDAs	Total Population across CBSDAs	Total Target Population	# of Physicians Engaged	# of Divisions in Place	# of CSCs in Place	# of Patients Receiving New/ Revised Services	% Reach
8	1,092,125	90,187	602	7	5	43,906	49%

2014/15 Deliverables for quick reference (summarized from bilateral report)

4.1 The HA will take action in collaboration with family physicians through GPSC to identify and better support (including the implementation of a shared care plans) the target populations to reduce avoidable ER visits, hospitalizations and delay or avoid admissions to residential care; HAs will report out on denominator of patient population and number of plans implemented

4.2 IPCC Service Delivery Platform is implemented or in process in minimally **100%** of community-based service delivery areas, by end of fiscal year. (March 31, 2015)

4.3 Report out on evaluation of progress linked to the development of v.6 of Integrated System of Primary and Community Care Service Delivery Platform end of September 2015.

REGIONAL - Major Progress and Key Accomplishments

A. Accelerated Integrated Primary and Community Care Initiatives (aIPCC)

Reference AIPCC Reporting; however, patient numbers are included in Community Based Service Delivery Area sections of this report.

1. Avoidance of Unnecessary Residential Care and Acute Admissions (AURAA)
2. Early Supported Discharge (ESD)
3. Frail Seniors Transition/Geriatric Transition Nurse (GTN)
4. Acute Home Based Treatment (AHBT)
5. Assertive Community Treatment (ACT)
6. Care Management/Home Health Redesign (HHR) including GP Care Conferences

B. Other Region-wide Integration Initiatives

- ***First Nations/Aboriginal Initiative –*** The goal is to facilitate the integration of the First Nations and Aboriginal services with the IPCC work. A final report of the First Nations / Aboriginal IPCC initiative has been developed for the period ending March 2014. Highlights of this initiative were:
  - The development and distribution of the inventory/map and analysis of "Availability and Levels of Access to Primary Health Care Services in the 14 First Nations Communities (on-reserve)" to internal and external groups.
  - An inventory/map of services used by Aboriginal people off-reserve/urban areas in Vancouver, North Shore and Richmond was completed was presented to VCH Senior Executive Team.
  - Engagement with First Nations communities was facilitated for VCH initiatives such as: Nurse Practitioner proposals, transition of services from United Church to VCH in the Central Coast by March 2014, and participation in local community IPCC steering committees in Powell River, Pemberton and the North Shore.

- ***Regional Intensive Complex Patient Care Planning (RICP2) Initiative –*** The goal is to create a regional shared care planning process that ensures a comprehensive approach for those who visited more than 1 urban ED site 20+ times during the year, and are referred to as "Familiar Faces" (FF). The 6 ED's are: LGH, RH, SPH, MSJH, UBCH, SPH.

- To date, 3 PDSA's phases have occurred on developing and coordinating an integrated community based approach to shared care planning for the FF population. A total of 33 Shared Care Plans (SCP) are completed or underway, which is 17% of the FF population (based on 2013 data), that have been completed and distributed across the 6 ED's involved.

- ***Integrated Primary, Community and Acute Care Steering Committee –*** Continued discussion on sustainment and standardization of aIPCC initiatives. The indicator-based IPCC Status Report was finalized.

- ***IPCC Regional Evaluation*** A regional survey to home health service providers/staff collected feedback on the Home Health Redesign initiative in order to improve change management processes. The online survey was conducted May 14-June 2 (20 days), and was sent to 579 recipients, with a completion rate of 21% (122 responses).

  Home Health Redesign Telephonic Care Pilot Evaluation is underway at Evergreen (12 clients transitioned) and Robert & Lily Lee (8 clients transitioned) clinics. Case Managers and Home Health Nurses at Robert & Lily Lee participated in a check in about the process, and identified successes, challenges, and insights into the client transition process.

  Evaluation plans have been completed for Home Health Redesign GP Care Conferencing and the Powell River prototype.

Key Issues / Opportunities for Improvement – New this quarter

Issues and Dependencies	Mitigation Strategies
1. Sustainment of IPCC and aIPCC initiatives	1. Develop sustainment plan with CoCs directors
2. Competing demand on staff time and resources	2. Involving staff in decision making; Develop clear workflow; Propose new position or change in roles for increased efficiency
3. Culture change among staff	3. Celebrate success, promote knowledge and change, work with change champions
4. Full Home Health Redesign (HHR) in Powell River and re-scoping of the rest of region fall created some confusion among staff	4. Change management leads working closely with Home Health (HH) managers and directors; Develop communication tools for HH Managers and staff
5. Standardizing GP care conferencing forms - mixed feedback from local sites	5. Involve front line clinicians in developing documentation forms; clarify purpose of forms for GP and clinicians
6. Funding for backfill during training to support change; Pay for Performance seems to be not an incentive for change	6. Reminder of future revenue
7. Accountability in implementing change in RICP2 project	7. Project Manager met with managers and directors-messaging with them; Engaged stakeholders through focus groups
8. Creating the Primary Care website as a central point for information on the IPCC project, resources, etc.	8. Review website content, train support staff and develop strategy to launch it
9. Approaching project end date (March 2015) and uncertainty post that date	9. Get clarification from the Ministry of Health and VCH senior leadership

QUARTERLY REPORT - INTEGRATED PRIMARY AND COMMUNITY CARE

Community Based Service Delivery Area: Powell River

Communities in CBSDA: Powell River

1	**Total population of CBSDA**	19,733
2	Target population(s)	Very High & High morbidity (esp. w/ cardio-vascular disease or Mental Health & Substance Use problems)
3	# of people in the target population	1,722 + 30 from Connecting Pregnancy = **1,752**
4	# of patients enrolled/receiving in new or redesigned services (cumulative)	▪ Intake redesign 35 ▪ Connecting Pregnancy 30 ▪ At risk users/ presenters to ED 286 ▪ Resource Navigator 16 ▪ Community partnerships • Building Recovery of Individual Dreams & Goals through Education/BRIDGES 40 • Promoting Community Wellness 399 ▪ aIPCC • GP care conferences 3 • GTN 1,066 **Total = 1,066** (Figure used to adjust for possible double counting) **or 61% of target population** Other patients served but not included in above total: Community partnership on Humble and Hearty Workshop and Monday Brunch whose clients may not be in the target population - 333
5	Division (In place, in progress, not started)	In place
6	# family physicians engaged	IPCC Steering Committee 2 Various initiatives 21
7	Status of CSC	In place
8	Collaborative Service Committee priority issues	• GP for Me • Resource navigation • CSC Strategic alignment • Home Health Redesign
9	Describe planned new or redesigned services (Key integration activities); AND Stage of planning & implementation	1. Intake redesign Sustain 2. Connecting pregnancy (Interdisciplinary primary maternity care group visits) Spread 3. "At-risk" users/presenters to ED Sustain 4. Health Resource Navigator Testing/pilot 5. Nurse Practitioners Sustain 6. Community partnerships Spread • Humble and Hearty Workshop (Powell River Employment Program Society) • Monday Brunch (Powell River Employment Program Society) • Building Recovery of Individual Dreams & Goals through Education/BRIDGES (BC Schizophrenia Society)

		• Promoting Community Wellness (The Source Club Society)
10	Care planning coordinated / shared care plans	Care planning is done in: • GP care conference with home health clinicians e.g. case manager, home care nurse.
	COMMENTS	

QUARTERLY REPORT - INTEGRATED PRIMARY AND COMMUNITY CARE

Community Based Service Delivery Area: North Shore

Communities in CBSDA: North Vancouver and West Vancouver

1	**Total population of CBSDA**	186,776
2	Target population(s)	Chronic, co-morbid/complex medical care needs
3	# of people in the target population	**17,570** (includes 2,200 Home Health clients, 15,220 high needs clients and clients of chronic disease nurses/coordinator)
4	# of patients enrolled/receiving new or redesigned services (cumulative)	▪ Chronic Disease Nurse Coordinator Program 165 ▪ High Needs (HealthConnection) Clinic 217 ▪ Chronic Disease Nurse in GP practices 837 ▪ Community partnerships • Counseling Service for Patients with Complex Health Issues 10 • Peer Support for Health and Wellness 15 • Golden Circle 235 • First Link (North Shore/Sunshine Coast 141 ▪ aIPCC projects • GP care conferences 283 • AHBT 556 • AURAA 245 • ESD 566 • GTN 3,700 **Total = 6,970 or 40% of target population** Other patients served but not included in above total: ▪ Community partnership projects 3,031 (from NS Keep Well Society who are active seniors and not likely to be Home Health clients or high needs patients)
5	Division (In place, in progress, not started)	In place
6	# family physicians engaged	Steering Committee 3 Various initiatives 84
7	Status of CSC	In place
8	Collaborative Service Committee priority issues	• GP for Me • Home Health Redesign • Health Connections (high needs unattached) clinic • Mental Health & Addiction • GP/Radiology Project • GP/Hospitalist Project • Breast Hub/Oncology Project

QUARTERLY REPORT - INTEGRATED PRIMARY AND COMMUNITY CARE

9	Describe planned new or redesigned services (Key integration activities); AND Stage of planning & implementation	1. GP care conferencing Sustain 2. Home and Community Care intake redesign Sustain 3. Chronic Disease Nurse Coordinator Program Sustain 4. Smart phone app (HealthConnection App on information about programs and services) Spread (official announcement of app launch in July) 5. High Needs Clinic (provides low-barrier primary care services for residents with complex needs and no access to family physician or Nurse Practitioner) Sustain. Positive results from evaluation are summarized in report inserted below.  G:\HealthConnection Clinic (Dept VCH)\Eva 6. Community partnerships Spread • Counseling Service for Patients with Complex Health Issues (Canadian Mental Health Association) • Peer Support for Health and Wellness (North Shore Neighbourhood House) • North Shore Keep Well (North Shore Keep Well Society) • Golden Circle (North Shore Neighbourhood House) • First Link
10	Care planning coordinated / shared care plans	Care planning is done in: • GP care conference with home health clinicians e.g. case manager, home care nurse. • Early Supported Discharge • Regional Intensive Complex Patient Care Planning (RICP2)
	COMMENTS	

QUARTERLY REPORT - INTEGRATED PRIMARY AND COMMUNITY CARE

Community Based Service Delivery Area: Richmond

Communities in CBSDA: Richmond

1	**Total population of CBSDA**	189,027
2	Target population(s)	Frail elderly: age 80+ and 70-79 with Alzheimer/ dementia
3	# of people in the target population	7,178 (age 80 & over) + 10,592 (age 70-79) = **17,770** *Note: Age 70-79 was added because GTNs target age 70 & over*
4	# of patients enrolled/receiving new or redesigned services (cumulative)	▪ Screening-Tracking Tool 50 ▪ Chronic Disease Management Clinic 138 ▪ Chronic Disease Nurses in GP practices 660 ▪ Community partnerships • Wellness Connections Program - 74 • First Link (Richmond/South Delta) - 594 ▪ aIPCC • GP care conferences 113 • AHBT 340 • AURAA 216 • ESD 384 • GTN 7,140 **Total = 9,709 or 55% of target population** Other patients served but not included in above total because of possible double count with abovelisted projects: ▪ Medication Card 44 patients during trial phase; ▪ Seniors Resource List 278
5	Division (In place, in progress, not started)	In place
6	# family physicians engaged	▪ Steering Committee and working groups 17 ▪ Various initiatives 130
7	Status of CSC	In place
8	Collaborative Service Committee priority issues	• Elderly care • Attachment GP4Me • Waitlist Reduction (Increase Patient Flow) • Home Health Redesign
9	Describe planned new or redesigned services (Key integration activities); AND Stage of planning & implementation	1. Standard referral form for all home health services and LTC 1 assessment report to GPs Sustain 2. Screening-Tracking Tool for the frail elderly Spread 3. Medication management Pilot completed. Evaluation results are summarized in insert below.  Medication Card Pilot Summary Report 27Ja 4. Senior's Community Resource List and Key Community Agency Partnerships - Spread

		5. Chronic Disease Management Clinic Sustain. Positive results from evaluation are shown in inserts below.  CDM Evaluation Report May2014.pdf 6. GP care conferencing Spread 7. Patient Flow and Care/Transition Planning/assessment. Sessions were held in the Spring to bring together Family Physicians, Home Health and Acute care staff to, among others, jointly identify priorities/or "always events" with the goal of improving patient care and flow. See below re 10 *Always events* and *Summary of the meeting between PC, Acute and HH staff* sent to participating GPs in April 2014.   May2014.Top 10 Always Events for Ca Summary Notes from March 13 Meeting FIN 8. ED-GP Just in Time Notification Trial Prototype/Pilot. The goal of the pilot is to improve communication with Family Physicians when their patients come to ED. The PC physicians have been asked to select their preference of communication: email, text or telephone. A second trial is being explored to provide information to GPs upon patient discharge from ED. 9. Community partnerships Spread ▪ Wellness Connections Program (Minoru Seniors Centre) ▪ First Link (BC Alzheimer's Society)
10	Care planning coordinated / shared care plans	Care planning is done in: • GP care conference with home health clinicians e.g. case manager, home care nurse. • Early Supported Discharge • Chronic Disease Management Clinic • Regional Intensive Complex Patient Care Planning (RICP2)
	COMMENTS	

QUARTERLY REPORT - INTEGRATED PRIMARY AND COMMUNITY CARE

Community Based Service Delivery Area: Vancouver- Downtown Eastside

Communities in CBSDA: Downtown Eastside Core

1	**Total population of CBSDA**	61,242
2	Target population(s)	Complex marginalized population
3	# of people in the target population	89 High ED users of St. Paul's Hospital who visited 10+ during the pilot year; 700 people living in 8 Single Room Occupancy hotels (SROs) Total = **789**
4	# of patients enrolled/receiving in new or redesigned services (cumulative)	• Integrated care process/care conferencing and care planning - 45 patients • Primary outreach services teams in 8 SROs -700 patients **Total = 745 or 94% of target population**
5	Division (In place, in progress, not started)	Under Vancouver
6	# family physicians engaged	IPCC Steering Committee and Working Group 8 Involved in the initiatives 24
7	Status of CSC	Under Vancouver
8	Collaborative Service Committee priority issues	Under Vancouver
9	Describe planned new or redesigned services (Key integration activities); AND Stage of planning & implementation	1. Integrated care process/care conferencing and shared care planning for complex patients Sustain 2. Primary Outreach Services Sustain 3. Community partnerships Sustain • Raincity Housing and Support Society • Portland Hotel Society Community Services
10	Care planning coordinated / shared care plans	Care planning is done generally during care conferences attended by health and non-health service providers.
	COMMENTS	

QUARTERLY REPORT - INTEGRATED PRIMARY AND COMMUNITY CARE

Community Based Service Delivery Area: Vancouver

Communities in CBSDA: All LHAs except Downtown Eastside

1	**Total population of CBSDA**	568,663
2	Target population(s)	Complex/Chronic patients
3	# of people in the target population	Complex patients *Note: Although no formal IPCC table, the target population of initiatives appears to be the complex population. Indicator of complexity used is the RUB score. RUB 4 & 5 (high and very high morbidity) =* **46,216**
4	# of patients enrolled/receiving in new or redesigned services (cumulative)	• Chronic Disease Nurses in GP practices 332 • Ideal Transition Home 6,639 patients • Post Discharge Follow-up Phone Call 480 • Home First 126 • Quick Response Team (RN and OT) 69 • EDiCare 2 per day or 90 since April 1 • Community partnership ▪ Access for All Supported Health and Wellness 7 ▪ First Link 312 ▪ Education Program for People Living with Arthritis - 511 ▪ Mental Health Wellness Support program - 34 ▪ Neighbourly Together - 52 • aIPCC ▪ GP Care Conferences 280 ▪ AHBT 320 ▪ AURAA 176 ▪ ESD 952 ▪ GTN 13,009 (lower # used to adjust for possible double counting with other initiatives) ▪ ACT 46 **Total = 23,435 or 51% of target population**
5	Division (In place, in progress, not started)	In place
6	# family physicians engaged	GPs of moderate to high risk patients rough estimate of 300 which half of Majority Source of Care GPs
7	Status of CSC	In place
8	Collaborative Service Committee priority issues	• GP for Me • Improving collaboration at the CSC • Mental Health shared care with community services
9	Describe planned new or redesigned services (Key integration activities); AND Stage	1. Ideal Transition Home initiative Sustain 2. Post Discharge Follow-up Phone Call Prototype/Pilot 3. Home First - Spread Home First is a care model focused on wrapping services and supports around frail and often very complex clients to support them to stay at home for as long as

	of planning & implementation	possible. For some clients a move to residential care may be avoided all together, while for others support may be provided for them to stay at home for a few weeks or months longer than anticipated. 4. Quick Response Team (QRT) - Spread The QRT works alongside the team in the VGH Emergency Department to determine which clients can be safely pulled back into their homes with community supports. The team will then help to coordinate the correct and required services to support the client with their local home and community care teams. 5. EDiCare - Spread To support communication and planning, comprehensive ED iCare Rounds are held daily with multiple acute and community stakeholders involved. Prior to and following ED iCare, the ED clinicians, TST and QRT have additional planning 'huddles' to finalize transition details. 6. Community partnerships - Spread • Development of COPD-related Educational Materials with an Appropriate Assessment of Health Literacy and Ethnic Needs (BC Lung Association) • Strengthening Community-based Resourves for Perinatal Depression and Anxiety (Pacific Post Partum Support Society) • Access for All (Langara Family YMCA) • First Link Expansion (Alzheimer's Society) • Education Program for People Living with Arthritis (The Arthritis Society of BC) • Mental Health Wellness Support Program (Mood Disorders Association of BC) • Neighbourly Together (South Vancouver Neighbourhood House) • Seniors for Seniors: Peer Training and Mentorship (Kitsilano Neighbourhood House) • Comprehensive Acute to Community Post-Discharge Patient Self-Care Management Package(BC Lung Association)
10	Care planning coordinated / shared care plans	Care planning is done in: • GP care conference with home health clinicians e.g. case manager, home care nurse. • Early Supported Discharge • Regional Intensive Complex Patient Care Planning (RICP2) • Transition plan transferred with patient from hospital to ED (Mod/high risk) • EDiCare to support transition from ED to home
	COMMENTS	

QUARTERLY REPORT - INTEGRATED PRIMARY AND COMMUNITY CARE

Community Based Service Delivery Area: Pemberton

Communities in CBSDA: Pemberton

1	**Total population of CBSDA**	**5,118**
2	Target population(s)	Population in Mt. Currie Reserve and Southern Stl'atl'inx
3	# of people in the target population	**1,800**
4	# of patients enrolled/receiving in new or redesigned services (cumulative)	▪ Telehealth - 20 ▪ Nurse Practitioner 1,080 ▪ Chronic Disease Nurse in GP practices 600 ▪ Community partnerships • Bowling for Life 50 • Self-Management Education (University of Victoria Self-Management Program) 8 ▪ aIPCC: • GP care conferences 7 **Total = 1,080** (figure to adjust for possible double counting) **or 60% of target population**
5	Division (In place, in progress, not started)	In place
6	# family physicians engaged	IPCC Committee and various initiatives 2 Various initiatives 3
7	Status of CSC	Not started
8	Collaborative Service Committee priority issues	
9	Describe planned new or redesigned services (Key integration activities); AND Stage of planning & implementation	1. Telehealth (E20 units) for healthcare providers and clients living in rural communities Pilot 2. Transportation services inventory Planning/assessment 3. Discharge information form to Pemberton Spread 4. Nurse Practitioner Sustain 5. Community partnerships Spread • Bowling for Life • Exercise 4 Brain & Neuro Health in Squamish • Self-Management Education (University of Victoria Self-Management Program) • School Board #48 (Sea To Sky) program for school age children to increase knowledge about mental health, sexual health and primary health care 6. aIPCC: ▪ GP Care Conferences Spread
10	Care planning	

	coordinated / shared care plans	
	COMMENTS	

QUARTERLY REPORT - INTEGRATED PRIMARY AND COMMUNITY CARE

Community Based Service Delivery Area: Squamish-Whistler

Communities in CBSDA: Squamish and Whistler

1	**Total population of CBSDA**	28,340
2	Target population(s)	To Be Determined
3	# of people in the target population	
4	# of patients enrolled/receiving in new or redesigned services (cumulative)	
5	Division (In place, in progress, not started)	In Progress MOU signed
6	# family physicians engaged	Squamish 15 Whistler - 5
7	Status of CSC	
8	Collaborative Service Committee priority issues	
9	Describe planned new or redesigned services (Key integration activities); AND Stage of planning & implementation	• *Squamish Integration Table:* First Nations Heath Director, local VCH leadership and local Division of Family Practice leadership have been meeting. • Divisions of Family Practice: Presented IPCC and GP Care Conferencing (GPCC) work at the divisions meeting. 9 GP's in attendance • Division of Family Practice Working Group: GPCC working group established. 2 GP and 2 VCH staff in attendance. Purpose of working group to roll out GPCC and improve VCH and GP linkages • The Productive Operating Theatre (TPOT) Working Group: Family physician participated in the productive operating theatre working group to improve the efficiency of operating rooms. • Iron Infusion Working Group: Working group created, including 2 family physicians, to review the guidelines for iron infusion and increase access and efficiency to ambulatory care *Whistler* • Concussion Working Group: Family physician and VCH staff and a member of the public working together to find opportunities to support clients in Whistler who have or are recovering from a concussion. • Introduced GPCC to the Whistler Divisions: next steps to provide education and orientation to MOA's Above activities are in Planning/assessment phase.
10	Care planning coordinated / shared	

care plans	
COMMENTS	

QUARTERLY REPORT - INTEGRATED PRIMARY AND COMMUNITY CARE

Community Based Service Delivery Area: Sunshine Coast

Communities in CBSDA: Sechelt

1	**Total population of CBSDA**	28,936
2	Target population(s)	To Be Determined
3	# of people in the target population	
4	# of patients enrolled in new or redesigned services	aIPCC: GP Care conferences 8
5	Division (In place, in progress, not started)	In place
6	# family physicians engaged	IPCC/Home Redesign 12
7	Status of CSC	In place
8	Collaborative Service Committee priority issues	• GP for Me • Mental health Pathways to Care shared care • HHR
9	Describe planned new or redesigned services (Key integration activities); AND Stage of planning & implementation	GP Care conferences Spread
10	Care planning coordinated / shared care plans	Care planning is done in: • GP care conference with home health clinicians e.g. case manager, home care nurse.
	COMMENTS	

QUARTERLY REPORT - INTEGRATED PRIMARY AND COMMUNITY CARE

Community Based Service Delivery Area: Central Coast

Communities in CBSDA: Bella Bella, Bella Coola, Kitsoo, Oweenko

1	**Total population of CBSDA**	4,290
2	Target population(s)	
3	# of people in the target population	**4,290** To Be Confirmed
4	# of patients enrolled in new or redesigned services	▪ Community partnership • Enhancing Child Development and Learning for Health and Well-Being Program 893 **Total = 893 or 21% of target population**
5	Division (In place, in progress, not started)	Not started
6	# family physicians engaged	
7	Status of CSC	
8	Collaborative Service Committee priority issues	
9	Describe planned new or redesigned services (Key integration activities) ; AND Stage of planning & implementation	• Establishment of an IPCC Steering Committee Planning At the request of the Health Directors in the central coast the primary health care team explored the options of establishing an IPCC steering committee or as it will be named in the central coast Collaboration tables. First meeting to happen in early fall • Family Physician in Bella Bella looking to improve office efficiencies establishing a working group to explore further - Planning • Community partnership Spread *Enhancing Child Development and Learning for Health and Well-Being Program* goals are to provide educational workshops, as well as on-site visits for follow-up meetings and application of information to four First Nations communities. OT provided the following workshops: ▪ Bella Bella 11 workshops for total of 376 participants, in addition to 5 Tech Talks for 89 students. ▪ Bella Coola 10 workshops for total of 295 participants, in addition to 4 Tech Talks for 86 students. ▪ Klemtu 6 workshops for 47 participants. ▪ Rivers Inlet 2 workshops to be completed March 17-19, '14.
10	Care planning coordinated / shared care plans	
	COMMENTS	

QUARTERLY REPORT - INTEGRATED PRIMARY AND COMMUNITY CARE

DEFINITIONS

Communities in CBSDA: _____

(USE ONE PAGE PER CBSDA Copy and paste this whole page if you have more CBSDAs)

1	**Total population of CBSDA**	
2	Target population(s)	
3	# of people in the target population	
4	# of patients enrolled in new or redesigned services	This is a cumulative number since the start of the initiative. Please break down my initiative or population groups where possible. Patients involved in more than one initiative may be double counted. At this point in time we will just need to be aware of this, and perhaps foot note it if you think an issue, but not get too caught up in double counts.
5	Division (In place, in progress, not started)	For Q1 Report, report as usual. Will discuss for Q2 if we want to acknowledge how many divisions the HA has a working relationship with on IPCC activities.
6	# family physicians engaged	For Q1, report as usual. This reflects collaboration of inter-professional teams in the development and delivery of service redesign, and will continue to be important under the new strategic plan. This will require further discussion to determine how to count this in a unified manner for Q2 and onwards.
7	Status of CSC	(In place, in progress, not started)
8	Collaborative Service Committee priority issues	Priority issues this quarter. Can copy/paste from previous report if no change.
9	Describe new or redesigned services (Key integration activities); **AND** Stage of planning & implementation	• Outline new or redesign services specific to the CBSDA here. If there are new integration activities occurring across multiple CBSDAs, you may prefer to address those on the first page under "Major Progress and Key Accomplishments" • Include the status of the program from the defined list: (1) Planning/assessment, (2) Prototype/pilot, (3) Spread, (4) Sustain (operational). If you need to acknowledge more than one stage, that's ok. Qualify that info here or in the comments section below.
10	Care planning coordinated / shared care plans	For Q1, report as you previously have. Further discussion required with WG to determine how each HA is counting number of shared care plans through multidisciplinary teams. (What is considered a team?). This will continue to be important with the Ministry new strategic direction and focus on inter-professional teams.
	COMMENTS	Section to describe more detail/particulars on any of the above captured data.