# Home Is Best NEWS

July 2013 | 1/2

## In this issue:



## Meet Dr. Peter Edmunds

We are very pleased to introduce Dr. Peter Edmunds, our new Regional Medical Director for Home, Community and Palliative Care. In this role, he will co-chair our Regional Home and Community Care Council.

Dr. Edmunds has been working for VCH as Coastal Medical Lead since 2009. He has led a number of innovative projects across community, residential and hospice care, and with the Coastal family physicians. Among his many contributions, Dr. Edmunds has increased client access to the North Shore Palliative Group, as well as created an urgent palliative care physician call group to support rapid access to PCU beds. The latter initiative resulted in a 30 per cent decrease in emergency admissions.

Outside his busy work life, Dr. Edmunds has an active young family and enjoys outdoor activities with his two boys.

## Provincial End-of-Life Care Action Plan

"The *Provincial End-of-Life Care Action Plan for British Columbia* is a key component of the province's health innovation and change agenda to achieve better health outcomes and experiences for British Columbians through a more efficient, sustainable health care system." [1]

"A key element of this approach is the early identification of individuals who would benefit from a care approach that focuses on the individual's quality of life to ensure the patient's symptoms and goals of care are identified and addressed appropriately. Incorporating the individual's journey, including the final stages of life, into discussions and planning for care, requires a shift for patients, families and health care providers who deliver their care. "[2]

For more detailed information, visit: www.health.gov.bc.ca/library/publications/year/2013/end-of-life-care-action-plan.pdf

[1 & 2] **The Provincial End-of-Life Care Action Plan for British Columbia, Ministry of Health, March 2013**

## Coastal Community of Care

**North Shore**

We are continuing to work on improvements to patient flow between acute and community transitions. Recently, we announced a change in reporting structure for the discharge care coordinators (DCC) at Lions Gate Hospital. Effective July 15, the DCCs will become part of the community care team, thereby further enhancing our progress towards the "ideal transition" to home.

We have also successfully piloted GP care conferencing with the intention of improving communication and planning between physicians and home health clinicians. Overall, 100 per cent of GPs surveyed believe care conferencing is a positive experience and the teams will be looking at how to incorporate it into their daily workflow.

**Powell River**

Home Health Redesign continues to forge ahead. Working groups have been developing and trialing the standard operating procedures required for the new model. Clinical experts from across the health authority are providing feedback on the draft procedures. Staff are piloting several of the new clinical processes that will be part of Home Health Redesign to ensure that they are efficient.

Community leaders and staff have held two successful events to inform and engage physicians in this important work as it is key to our success.

This month, we also began the exciting work of looking at future staffing models.

# Home Is Best NEWS

July 2013 | 2/2

## Richmond Community of Care

bestPATH, which stands for best Person-centered, Appropriate, Timely Healthcare, is a strategy in Richmond to provide the right care, in the right place, at the right time, in a positive and supportive environment. It links acute, community and primary care physicians together to enhance the care and transition experience for patients and clients, and to improve workflows for staff and physicians.

The first phase of bestPATH has been about understanding our current state and beginning to explore the ideal, future state for three streams of care in Richmond: primary, community and acute. We conducted information sessions with patients, clients and their families to understand their journey when cared for by the acute medicine and/or community care teams.

As we begin to plan for Home Health Redesign, it makes sense to fold the community stream of bestPATH into Home Health Redesign as one initiative. Our goal is to build on the excellent work done to date in Richmond community. The work of the bestPATH acute stream and transitions into community will remain distinct but will align with Home Health Redesign.

## Contacts

**Shannon Berg** (Regional)
604-875-4673 | Shannon.Berg@vch.ca

**Irene Street** (Richmond)
604-244-5213 | Irene.Street@vch.ca

**Janice Lochbaum** (Vancouver)
604-708-5305 | Janice.Lochbaum@vch.ca

**Laurie Leith** (North Shore & Sea to Sky)
604-984-3862 x 3862 | Laurie.Leith@vch.ca

**Lauren Tindall** (Sunshine Coast)
604-885-8614 | Lauren.Tindall@vch.ca

**Lu Wuthrich** (Powell River)
604-885-8614 | Lu.Wuthrich@vch.ca

## Vancouver Community of Care

Home First remains at the centre of everything we do. It's a transition management approach to keep patients safe in their own homes for as long as possible, with community support. Patients are now assessed using standard operating procedures (a package of six documents finalized this spring). This ensures a consistent process is applied to each individual case. Home First recognizes that patients and their families have a role in partnering with heath care providers during their care.

Vancouver's new Quick Response Team (QRT) launched in July. The three-person team – two registered nurses and an occupational therapist – is assigned to patients that are known and unknown to community services, who are at risk of a hospital readmission after being discharged. Once at home, patients receive immediate follow-up care (same day to within 48 hours) from the QRT. Intensive QRT follow-up, involving the patient's GP and acute care partners, continues for as long as 10 business days, until all necessary care supports are in place to ensure the patient thrives at home and their risk of readmission to hospital is mitigated. So far the team has achieved their target of 100 per cent for preventing re-admission within seven days in high risk patients!

Another key activity this summer is our Transition Services Team (TST) review. Based on the current state map for TST, the purpose of this project is to generate a future state that takes into consideration the role and scope of all teams and clinicians involved in transition work. The review team meets weekly and a model will be ready for implementation this fall.

We've also completed a review of Home ViVE and Home ViVE+. The review's goal was to optimize program capacity, validate existing mandates and support planning for the future of the programs.

***"The goal and focus of health care professionals should be to return seniors to their homes and communities as soon as possible so they can regain their independence and lead full lives."*** *- VCH client*