Divisions of Family Practice
A GPSC initiative

# Case Study - Health Integration

*To read the full story on health integration, click here.*

As a concept, healthcare integration is very popular but it's the implementation process where many organizations struggle. The Fraser Health Authority is redesigning its Home Health services and with help from the Divisions of Family Practice, they are improving access to community health services for patients.

## Problem:

- General practitioners (GPs) were disconnected from Home Health case managers who coordinate care for people with complex care needs requiring ongoing support to live at home independently. Prior to 2010, when it came to the home care of elderly or disabled people, both groups were feeling out of the loop with each other when it came to the care of their patients.
- Case managers were responsible for patients within a geographic area, but often weren't in communication with the GP on the health status or care plan for the patient, which led to gaps in the care of the patient.
- Because of the disconnect between GPs and case managers, patients receiving long-term home health services weren't receiving coordinated care. As a result, the patients ended up visiting hospitals more frequently or being placed in residential facilities, leaving a system that was inefficient, fragmented and costly.

## Solution:

- The Fraser Health Authority (FHA) recognized the disconnect and began collaborating with the Ministry of Health and the Divisions of Family Practice to create an initiative that integrates the work of the health authority and the GPs. As a result, the Home Health case manager-GP partnership initiative was created.
- Case managers are now assigned to a specific physician's practice and communicate with GPs on patients they share. This allows them to better support the patient or their caregiver in addressing their care needs and improves their ability to coordinate services for their patients.
- GP's with clients on the Home Health long-term program now have one person to call when they need to discuss the status of their Home Health patient. Case managers and GPs are "in the know" about what the other is doing and how their care is complementary.
- Baseline patient surveys were helpful in demonstrating the effectiveness of this initiative. The patient survey conducted in Chilliwack reported a dramatic decrease of overnight hospital stays over a twelve month period.

- The patient now has more comprehensive care.
- This example of integration and collaboration has been successfully implemented in Chilliwack, White Rock/South Surrey, and Abbotsford. It is in the process of being implemented in Maple Ridge and Mission. Through collaboration with all Divisions of Family Practice in the FHA area, the Home Health initiative will be implemented in every community of Fraser Health within the next two years.

## Successful Integration:

Dr. Grace Park, the Medical Director of the Home Health program and also a board member for the White Rock/South Surrey Division of Family Practice, along with Director Irene Sheppard, attribute the program's success to partner collaboration and integration of resources.

- There was recognition from all partners involved that a care gap existed in the way home healthcare was being provided.
- Gaining strong input from GPs and case managers was essential to improve all aspects of patient care but also to gather feedback on how everyone wanted to work together.
- All partners were engaged in the development and implementation of the program.
- Everyone had the same common goal and worked as a team, instead of separate entities.

The Home Health initiative is a great example of the Triple Aim initiative, which is to improve the health of the population, enhance the experience of care for patients, families and provider and reduce or control care costs.