Fraser Health and Divisions of Family Practice introduce team approach to home health

The concept of health care integration is often discussed, but many organizations have struggled to implement it. In the Fraser region, the Fraser Health Authority (FHA) has partnered with local divisions of family practice to integrate its home health services with the primary care delivered by family physicians. The program is based on a pilot undertaken a few years ago in the Fraser Health communities of Coquitlam, Port Coquitlam, and Port Moody. FHA has worked with divisions to introduce it in Chilliwack, and based on learnings there it has been expanded to White Rock–South Surrey, Abbotsford, Ridge Meadows, and now Mission.

Home health case managers coordinate care for people with complex needs who require ongoing support in their homes. Historically, they were responsible for a geographic area and saw as many as 100 patients who were associated with over 66 different family doctors. As a result, there was little communication between caregivers, patients weren't receiving coordinated care, and hospitalizations and residential care placements were frequent. The system was fragmented and costly.

To introduce a better-coordinated, team approach to care, FHA has worked with Divisions of Family Practice, which provide a connection to FPs in each community. The first step is for a local division's collaborative services committee (CSC) and board of directors to confirm their intent to participate.

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Next, FHA updates each patient's assessment and confirms who the family doctor is. Case managers are matched to specific FPs, and take on care for those doctors' patients. The GPSC community conferencing billing fee code enables family doctors to hold regular meetings with their case managers—often an hour long—to discuss patients and develop care plans.

In addition to improving patient outcomes, family doctors involved say the program is helping to streamline their work, and is making the system more efficient through reductions in prescriptions, hospital visits, and long-term care admissions.

Divisions organize events to introduce physicians and MOAs to the program, and physician ambassadors volunteer to work with FHA's change management team to advise their colleagues of the initiative.

FHA leads the change management to ensure effective transitions and engagement by physicians. It has also created two new positions in the home health offices to free up the case managers' time to work with FPs. A surveillance nurse position oversees more stable patients, and a client service assistant helps with the administrative and logistical elements of the integrated care teams: coordinating meetings, helping to obtain financial information, liaising with families, and giving the case managers more time for hands-on, clinical care.

The goal is to implement the program across all 14 home health offices in the region. Implementing the initiative one home health office and division at a time has enabled FHA to evolve its approach. Physicians and home health case managers both report that communication and collaboration are greatly improved. For patients, the benefit is more homogenous, proactive care and less need for acute care. In addition to improving patient outcomes, family doctors involved say the program is helping to streamline their work, and is making the system more efficient through reductions in prescriptions, hospital visits, and long-term care admissions.

Dr Grace Park, medical director for FHA's Home Health program and a member of the White Rock–South Surrey Division of Family Practice, says the integration has been successful so far for a number of reasons: both FHA and family doctors agreed there was a gap in the way care was being managed and had a common goal for improving it; the partners worked as a team on initial program design and implementation; FPs and case managers have provided input to and feedback on program improvements; and this feedback is leading to incremental changes that are helping enhance the program's effectiveness with each new community.

—Brian Evoy, PhD
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