**DTES Invitation to Innovate Submission**

**Organization Name & Address:** Vancouver Coastal Health – Integrated Primary Acute & Community Care; 903-601 West Broadway St, Vancouver, BC

**Key Contact Persons:**
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**Summary Statement:** To create a multidisciplinary and integrated VCH-staffed clinical community team dedicated to develop, coordinate, and maintain Shared Care Plans for high ED users (Familiar Faces) from the Down Town East Side area who frequent: St Paul’s Hospital (SPH), and/or Mount Saint Joseph’s Hospital (MSJH), and/or Vancouver General Hospital (VGH).

**Further Detail:**
This Integrated Clinical Team (ICT) will be comprised of clinicians offering expertise from three sectors, namely Mental Health & Addictions, Home Health, & Primary Care. The goal is for this team to develop Shared Care Plans (SCP) and to consistently coordinate the care needs for each of the Familiar Faces (FF) who reside in the DTES. The objective is for one SCP Coordinator to organize the SCP with involvement from all relevant clinicians, thereby mitigating the scenario of multiple case managers of different sectors working in silos. The team coordinator will also collaborate with dedicated ED team members (such as Social Workers) as part of organizing the care. The team will also span their work with and across all 5 Community Teams namely, DCHC, Strathcona MY&A, Pender CHC, Primary Outreach Services, & Native Health.

Strong leadership supporting collaboration is key to implementing a successful dedicated ICT. The leadership role will be one who offers a cross-discipline experience and lens. This person will oversee operations and innovations to achieve efficiency and effectiveness that positively impact client and provider experience and health outcomes. The ICT leader will: ensure evaluation and measurement are in place to track and measure deliverables, oversee quality & safety improvements as described by evidence based practice, enhance collaborative relationships, and manage strategies that align with the Downtown East Side (DTES) vision.

**Outcome measures:** 1. Comparative pre-post intervention quantitative data on ED visit rates, admission rates to hospital, and length of stay; 2. Qualitative measures on patient experience, provider experience, patient health outcomes; 3. Financial measures would calculate dollars saved by bed days saved and ED visits saved.

**Conditions/Health Challenges Addressed** - This initiative would address a wide variety of health conditions, as the population presents with complex medical and/or mental health and addictions issues. Many have housing issues and are marginalized.

**Client Population:** This client population is mostly middle aged, but does span all age groups. Familiar Faces are from all ages, backgrounds, ethnicities, genders, and cultures. This program does not include the severely addicted and mentally ill (SAMI) population.

**How this will improve services:**

A Patient and Family Centered Approach: Partnering with clients and inviting them to be part of their care planning will lead to engagement, and thus a likelier chance of them engaging in steps towards health goals that are meaningful to them.
Robust Care Coordination & Strengthening Collaboration: This initiative will strengthen collaboration across the care continuum namely, the new ICT, VGH & SPH ED’s, primary care physicians, specialists, community teams such as housing, and any other external/internal community stakeholders. Virtually, all care givers involved with a client will “be on the same page”. Consistent messaging to the client will result at whatever touch-point the client interfaces with.

Preventative Approach: The SCP also is a safe approach to care, as all clinicians will have the same information on the client which yields more accuracy across continuum. Data can be pulled every quarter to identify those clients who visit the ED at SPH &/or VGH 4 times or more per quarter to identify early who is at risk of being a high ED user.

Evidence – There is extensive literature available on the benefits of Shared Care Planning for high ED users such as: reducing ED visits, improving patient experience, improving patient health outcomes, and improving provider experience. Extensive baseline data gathered from 2 recent VCH initiatives namely, Regional Integrated Complex Patient Care Planning (RICP2) and the DTES Care Planning project demonstrate that this Shared Care Planning not only reduces ED visits, but also improves the care experience, reduces staff compassion fatigue both in the ED and in the community sector, and engages physicians and specialists who often work in silos.

Links with DTES services – This work straddles many DTES services such as: MH teams, housing teams, psychiatric services, the Assertive Community Treatment Team (ACT) physicians, probation officers, ambulance services, and RCMP, to name a few.

Cost Estimates: Yearly costs for this ICT would be:
- 1 DTES Regional Team Leader – (SW or NP) - $100,000/year
- 3 Team Clinicians (MH&A, HH, PCC) - $300,000/year
- 2 .5 FTE’s SW at SPH & VGH (1 per site) - $100,000/year
➢ TOTAL Expenses (approximation) = $500,000 in salaries
Estimate does not include: training costs, equipment or additional space required

Alignment with Second Generation Strategy Vision:
- Addresses complex & chronic conditions – medical, mental health & addictions
- Offers robust coordination of care across continuum
- Flexible approach/services for meeting client where he/she is at
- Open for all DTES clients who fit the Familiar Face criteria, regardless of age, background, race, ethnicity
- Coordination with other services, in particular, housing teams
- Sharing of client information & data across the care continuum
- Engaged leadership to ensure quality, empathetic approach & ongoing evaluation
- Supports staff wellness
- Helps realize vision of integrated care

Respectfully Submitted by:
Laura Cross & Venie Dettmers
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