Home Is Best NEWS

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

HOME IS BEST

February 2013

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What is Home is Best?

Home is Best is an approach to care and service delivery, based on current evidence that:

- Home is the best place for a person to live, as long as they are safely able to do so and they have the appropriate supports.
- Home is the best place to recover from illness once hospital care is no longer needed.
- Home is the place where most people who have a life-limiting disease would choose to stay as long as they have supports

A number of initiatives in each Community of Care fall under the "Home is Best" umbrella. Some examples include Home First, AURAA, and Ideal Transitions Home.

Research shows "post-hospital syndrome" links to re-admissions

For many years, evidence has shown that people generally recover faster from illness when they are in their home setting.

A recent article by Harlan M. Krumholz in the New England Journal of Medicine (386(2): 100-102) summarizes what is known. Krumholz discusses the link between "post-hospital syndrome" (unintended consequences of care in the hospital) and re-admissions to acute care. Many factors that precipitate a re-admission to the hospital are not related to the admitting diagnosis. Krumholz notes that:

- Patients in hospital commonly deal with disruptions in sleep patterns and changes in food.
- They often experience pain and discomfort and receive new medications that their body must adjust to.
- They are likely to experience de-conditioning due to bed rest and inactivity.
- Patients meet a variety of health care professionals, with no time or context to understand their roles, and deal with unpredictable schedules and information overload.

The cumulative affect of these stressors may also lead to delirium. While patients are in hospital and after they return home, care plans for these patients should include strategies to mitigate these various factors.

Coastal Community of Care

The Coastal sites are well underway with the Home is Best strategy. The North Shore, Sea to Sky, Sechelt and Powell River sites are working within their teams to support smooth transitions for patients being discharged from acute care to community. The AURAA patient-focused funding fostered the ability for acute care teams to work with their community partners to ask the question: "What will it take to support this patient's discharge to their home environment?"

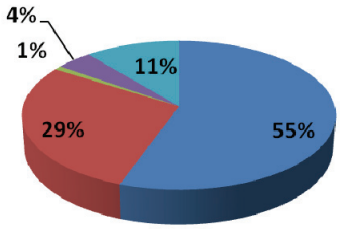
The North Shore has hired a Rapid Response Nurse Practitioner (NP) who supports the Home is Best strategy. Patients who are considered to be a complex discharge or over the age of 80 years are automatically referred to the NP for a home visit within 48 hours post discharge from hospital. The NP also works within the Evergreen residential care home and the North Shore community to respond to clinicians need for rapid support of a declining patient condition. The NP provides patient assessment and treatment and will liaise with the patient's family physician to communicate and confirm a plan of care. We are currently exploring the opportunity to replicate the Rapid Response NP in some of our other Coastal sites.

Coastal is also in process of mapping the patient journey from acute to community to determine what essential steps and related information is required at each transition point through the health care system. There are many opportunities for enhancements to our current processes with the ideal goal of achieving quality patient care.

"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

Richmond Community of Care

Since Home First began in Richmond in May 2011, we have been able to support clients to wait at home for residential care placement and to avert admissions into residential care completely. Here is as a snapshot of our successes to date.



- 55% of clients are still at home, after more than 19 months
- Only 29% were admitted to residential care
- Only 4% of clients declined or closed all services
- 1% were admitted to hospice
- 11% of clients were supported to die at home

The quantitative measures are important in tracking our successes; however, the difference that Home First has made for clients and families speaks volumes about the quality and success of our program.

Here is one daughter's testimonial. Her mother went home to await residential care placement. It has been over a year since she was discharged and the client has decided that *Home is Best* and remains at home.

"If it had not been for Home First my mother would not be here today. She was meant to go to the extended care facility and would have probably passed away by now. But instead, I had lunch with her on the deck at a restaurant in Kerrisdale."

Contacts

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

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

Petra Pardy (Richmond)
604-244-5213 | Petra.Pardy@vch.ca

Laurie Leith (Coastal)
604 313 9615| Laurie.Leith@vch.ca

Gerry Latham (Sunshine Coast)
604-885-8614 | Gerry.Latham@vch.ca

Brenda Langevin (Sunshine Coast)
604-885-8614 | Brenda.Langevin

Vancouver Community of Care

Home First gained momentum throughout 2012 in Vancouver; thanks to several on-going and strategically-linked initiatives launched under Home is Best.

Over the past year, Home First resulted in the following successes:

- Home First initiative joins Ideal Transition Home initiative at VGH under umbrella of Home is Best
- Decreased residential care registrations (down 14 per cent over two years)
- Provided opportunities for frail seniors to stay at home to make life-changing decisions

Not only has Vancouver Community moved closer to meeting its regionally defined targets for reducing residential care registration rates and delayed placement of residential care clients, but we're also well underway toward establishing a series of standard operating processes (SOPs).

These SOPs will help staff transition acute patients back home to wait for residential care placement or to delay residential care placement altogether. They are in final draft and will be ready for implementation with acute and community staff shortly.

While much of the initial work accomplished in 2012 was focused on VGH, 2013 will see us moving forward with the introduction of Home First strategies into our Providence Health Care hospital sites – St. Paul's and Mount Saint Joseph – with the full support of PHC staff and leadership.

We're also excited about the upcoming launch of our new Quick Response Team pilot project; the QRT, for short.

The team will provide targeted community-based response (within one to two days of discharge from acute) by a nurse case manager. The QRT will be trialed with select patients who are at high risk of acute care readmission. Patients will be seen by the team for up to two weeks and transitioned to follow up from their GP or to other available community services or supports.

The first patients will be referred to the QRT on February 18, and we expect the team to expand to include more nurses and rehabilitation specialists.

The pilot project will be closely monitored and evaluated, and we look forward to sharing our results and learnings with the regional Home is Best team in future editions of this newsletter.