# Faculty/Presenter Disclosure – All presenters

Faculty: NA

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- Other: NA

Chilliwack
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A GPSC initiative

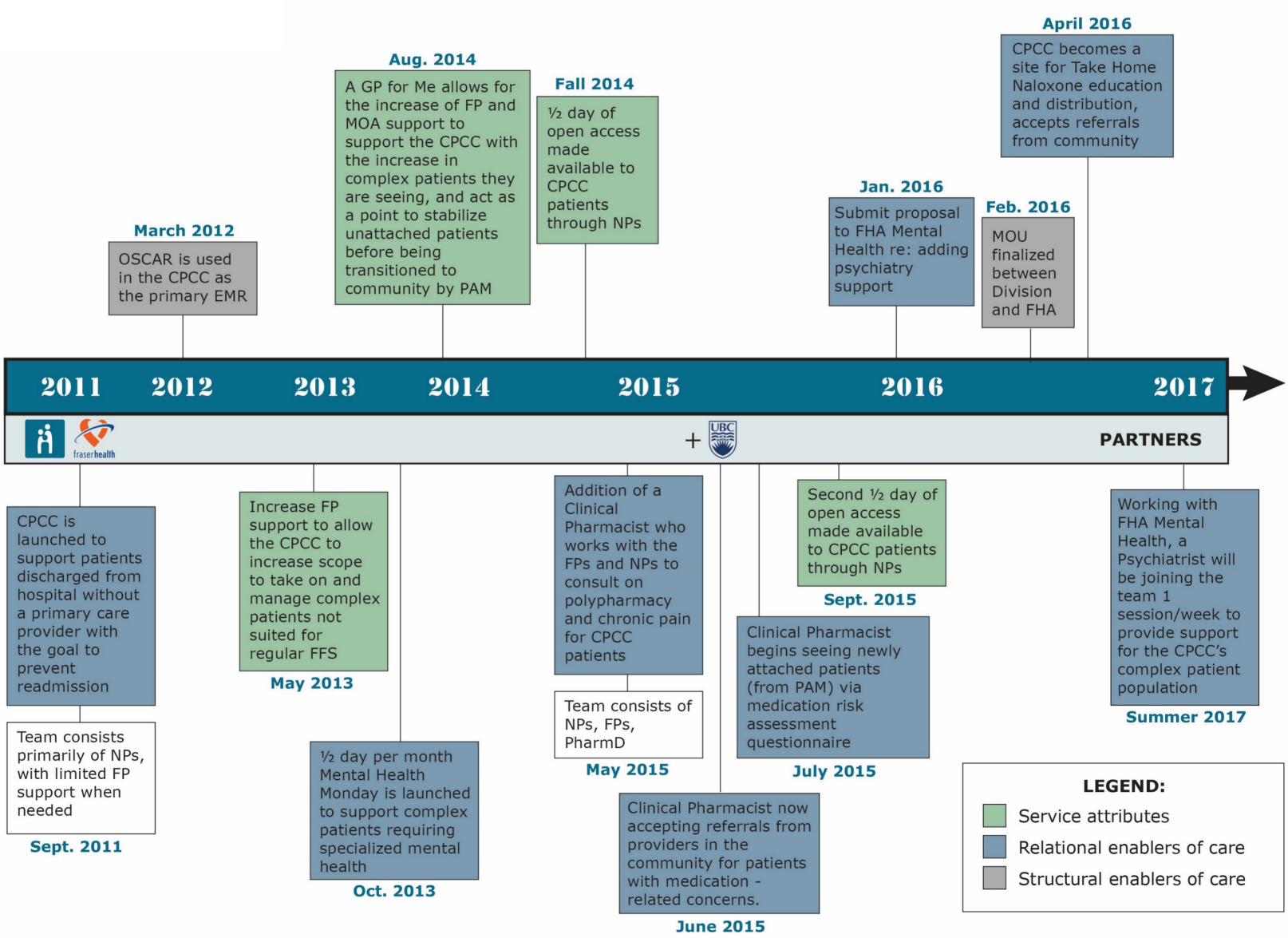
fraserhealth

# Partnerships Improving Health Trajectories

**Chilliwack Division of Family Practice and Fraser Health Authority**

GPSC Fall Summit

November 28th, 2017

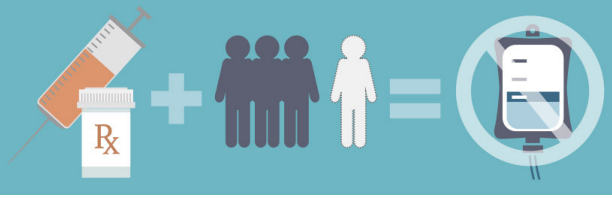



Between August 2014 and June 2016, on average, a group of vulnerable patients are estimated, **per patient**, to have **avoided 1.3 ER visits**, and **~19 acute care bed days**."

In total, attachment to a family doctor for these patients has resulted in **150 fewer ER visits** and **1,634 fewer acute care bed days**.

# A man in his 50s was previously homeless.

He was dealing with drug abuse and social issues that hindered his ability to complete chemotherapy for his colon cancer.




He moved to Chilliwack in 2012.

In 2012, he had 4 ER visits.

In 2013, he had 3 ER visits.

He started with the CPCC in June 2014.


In 2014, he had no ER visits because he is being cared for at the CPCC.

He is currently staying clean and is not on any benzos or narcotics.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# A man in his 60s was diagnosed with renal cancer.

He did not have a family doctor prior to this.

He was supposed to undergo surgery for this within 1 year; instead, he fell through the cracks several times because he had no consistent primary care provider.

His medication included 2 high doses of benzos and M-Elson, 75 milligrams 3 times a day.


In 2012, he had 10 ER visits.

In 2013, he had 16 ER visits and 2 hospital admissions.


He started with the CPCC in August 2013.


In 2014, he had only 4 ER visits.


He has now been totally tapered off his long acting narcotic and is only taking one benzo.

He now has a family doctor in the community and has had surgery for his renal cancer.

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# A woman in her 50s

was a previous patient of a family doctor in the community who stopped prescribing narcotics.

She was on 1 benzo and Tylenol 3.

She had 24 ER visits in 6 years. Most of these ER visits were medication related.

2008 2009 2010 2011 2012 2013

She started with the CPCC in November 2013.

In 2014, she had 4 ER visits. These were all due to complications of a fractured ankle, none due to medication.

**She is now off benzo and her Tylenol 3 medication is being slowly reduced.**

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# A very frail main in his 60s

with complex health issues had no family doctor in the community.

In 2010, before starting with the CPCC, he had 10 ER visits, including 7 admissions.

He started with the CPCC in November 2010.

In 2012, he had 8 ER visits.

6 were due to 2 Motor Vehicle Accidents.

In 2011, he had 2 ER visits.

In 2013, he had 5 ER visits and 1 hospital admission. These were all related to an acute illness and dealt with by the PCC doctor during the admission.

In 2014, he had no ER visits.

## He now has a family doctor in the community.

He was on increasing doses of morphine and is now stable on fentanyl patch. Multidisciplinary pharmacy and home health care is being coordinated by his GP.

He is still able to live in an apartment on his own. Keeping a frail BC senior in their home and out of residential care can **save an average of $43,018 yearly.**

*The Picture of Health in Chilliwack, Fraser Health, November 2014.*

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# Creating and Strengthening Partnerships

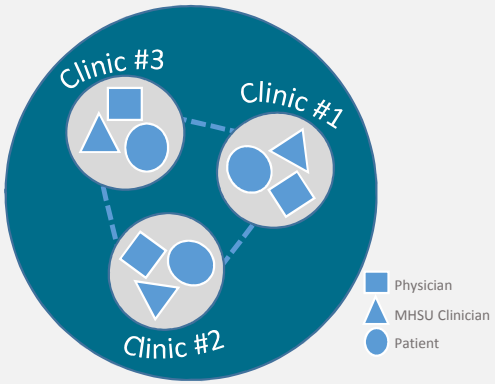
## Health Connections Clinic


*Team Based Care*

island health

Comox Valley Division of Family Practice
A GPSC initiative

## MHSU Support For Physicians




*Embedded in Primary Care*

## Community Navigator


*Community Partnership*

Comox Valley Transition Society

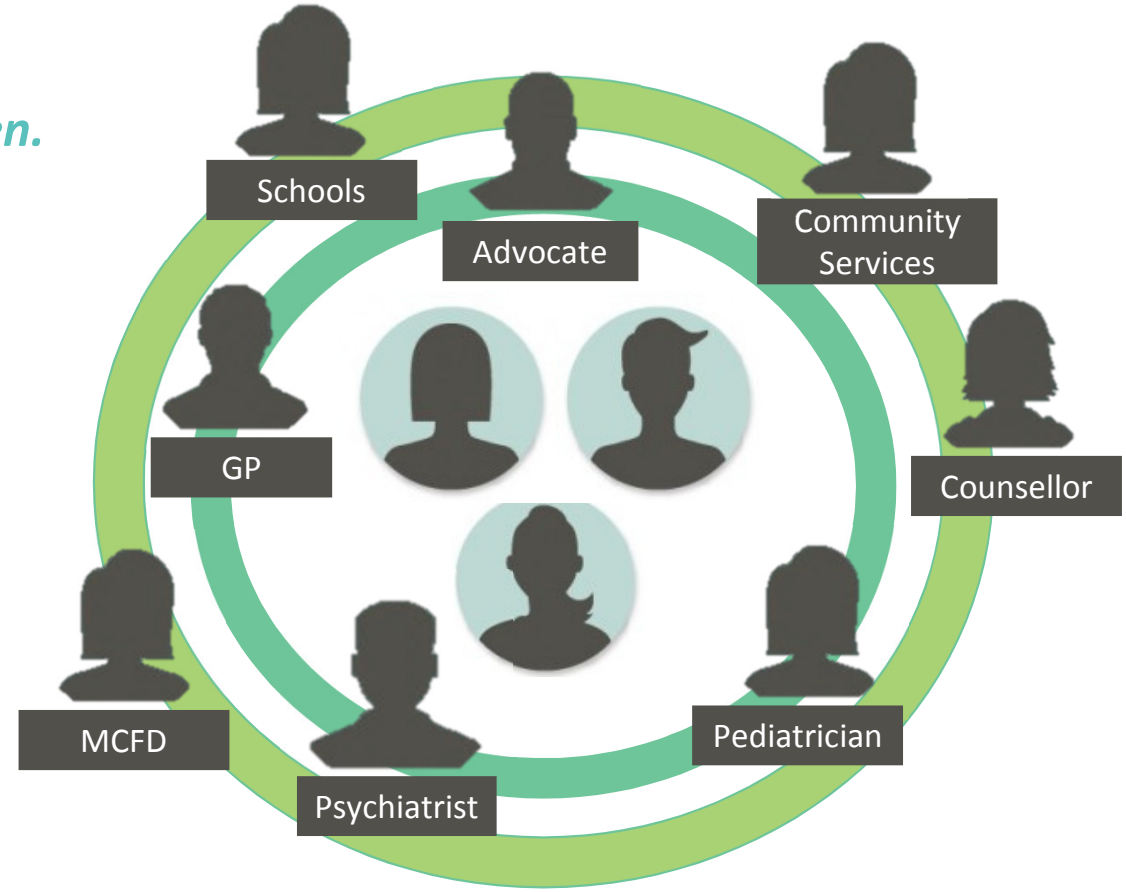
Comox Valley Division of Family Practice
A GPSC initiative

# Impossible to Possible.

***Community Partnership Making it Happen.***

**GOAL:**

***To increase the number of children, youth and their families receiving timely access to integrated mental health and substance use services and supports.***




Youth Wellness Centre

Maple Ridge/Pitt Meadows Community Services
*Changing Lives Together*

Ridge Meadows
Division of Family Practice
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