iCARE & Ideal Transition Home

What is iCARE & ITH?

At Vancouver Coastal Health (VCH), we've integrated two care models for one very important reason: our patients.

Developed and implemented by an inter-professional care team, iCARE & ITH is a seamless model of care integrating:

- **iCARE:** a care-planning methodology we use to deliver quality care, reduce delays and eliminate barriers to discharge
- **ITH (Ideal Transition Home):** a standardized methodology we use to proactively identify patients at risk for readmission and facilitate their safe, successful transition home.

What are our goals?

Enhancing the patient's journey
Providing best care is at the heart of our True North goals and the primary motivation for all we do. With iCARE & ITH, we aim to:

- deliver individualized, quality care
- enhance the patient journey across the continuum of care, including community and primary care
- help patients resume life in the comfort and familiarity of home, or a safe and healthy alternative

Increasing capacity
Freeing hospital beds and increasing our capacity to deliver quality care are important, too. With iCARE & ITH, we're reducing delays, eliminating barriers and improving transitions to community care in order to:

- reduce the average length of hospital stay
- reduce readmissions to acute care

2013 3M Health Care Quality Team Award

At the 2013 National Health Leadership Conference, the VCH iCARE & ITH Working Group outshone 13 competitors from across Canada to win the 3M Health Care Quality Team Award (Acute Care). This highly regarded award recognizes innovation, quality, teamwork — and, of course, the outcomes of implementing iCARE & ITH.

iCARE & ITH: Putting People First

Within 48 hours of admission, we assess the patient, identify barriers to discharge and determine whether the patient is at risk for readmission. We also ...

... inform the family physician of the patient's admission and explore the potential for an appointment within 48 to 72 hours of discharge.

We conduct inter-professional and physician rounds daily to focus on what is best for the patient, and to eliminate barriers to returning home safely.

Enhanced collaboration in hospital — and with our community partners — helps us maintain a seamless continuum of care.

As the patient readies to return home, we provide the information, tools and peace of mind to make a successful transition.

The patient's My Discharge Plan summarizes hospitalization and outlines next steps and contacts for care in the community. We provide this plan to the patient/family, the family physician and our community partners in care.

We teach the patient about the signs and symptoms of his or her condition, and ...

... we update the family physician, arranging for an appointment within 48 to 72 hours of discharge.

For consistency and continuity of care, we follow up with the patient, the family physician and other health care partners in the community after discharge.

Working together, we're enhancing the patient's journey, freeing hospital beds and strengthening inter-professional teamwork.

Visit VCH on YouTube and watch our video iCARE & Ideal Transition Home: Putting People First

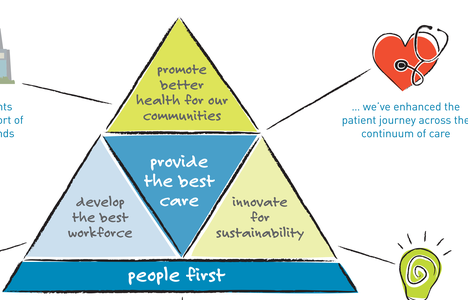
Rose Lachance
Patient of Vancouver General Hospital

What have we accomplished?

iCARE & ITH is making a difference. Implementation across VCH-Vancouver's medicine units has had positive results supporting our True North goals. Now, we're building on our success and implementing this proven model of care across surgical units.

VCH True North Goals

... we've helped patients resume life in the comfort of home, family and friends



... we've enhanced the patient journey across the continuum of care

... we've strengthened inter-professional teamwork

... we've increased capacity by more than 40 medicine beds per day and reduced readmissions by 2.2%†

† Based on CIHI readmissions methodology.

... we've implemented a new model of care that benefits patients, staff and our GP partners in the community

Vancouver CoastalHealth
Promoting wellness. Ensuring care.