s.21 [redacted]

RFEOI 2018-BISS-011

Personal Health Care Hub (HCH) and Urgent Primary Care Center (UPCC)

Vancouver Costal Health

Delivery Date:	November 22, 2018
Presented To:	**Vancouver Costal Health** Joseph Zhou Manager Vendor Selection Procurement@vch.ca T: 604-829-2565
Submitted By:	s.21 [redacted]

[redacted]

RFEOI SUBMISSION

[redacted] is the largest network of integrated community health services in Canada, with a national interdisciplinary network of health care and support professionals of over 13,000 strong. As we have expanded and evolved our practice, we have become experts in identifying healthcare system gaps and working with community partners to improve access to quality care, outcomes for individuals and organizations and system efficiency [redacted] combines deep clinical capabilities and a partnership oriented approach to optimize service delivery, achieve key performance and value benchmarks and deliver better health outcomes. Our clinical and support professionals work together to maximize results and share best practices from across the country. For the past 40 years, [redacted] has led the industry with a dedicated approach to integrating clinical practitioners and services and has helped to shape healthcare standards and practices across the country.

[redacted] **Include:**

[redacted]:
[redacted] owns and operates over 250 multidisciplinary centres across Canada, which provide comprehensive services in physiotherapy (PT); occupational, kinesiology and rehabilitation therapies; independent assessments; vocational assessments and rehabilitative programs for a variety of clients, insurers and employers.

[redacted]
[redacted] provides integrated community-based services across a variety of settings (schools, long term care facilities, private homes and workplaces) and age groups (preschool age to the elderly) in both private and publicly funded systems.

[redacted]
Innovative service care models that provide integrated and immediate access to high quality rehab programs and alternate funding solutions in partnership with publicly-funded hospitals. These alliances create the foundation to expedite discharge by providing enhanced community programs.

[redacted]
In the past, [redacted] owned and operated a group of 13 Specialty, walk-in and family medical services. [redacted] continues to have a strong core of dedicated physicians working within our interdisciplinary team that bring considerable knowledge of the community medical network, and a wealth of great relationships to draw upon.

[redacted]
Providing expert health and safety services to employers to reduce risk and injury in the workplace and expedited access to medical and rehabilitation services including health and wellness consulting.

[redacted]

[redacted]

An integrated, interdisciplinary approach to the diagnosis and treatment of autism spectrum disorders (ASD) in children, youth and adults. The clinicians at Monarch House improve access to required services, coordinate treatments, and focus on meaningful outcomes for individuals of all abilities. Our services can occur in our centres, clients' home and school, in the community, and in specialized housing settings.

[redacted] Services

Independent assessments and expert opinions of medical impairments and functional abilities.

[redacted] Services

Specializing in the provision of PT and OT to elder populations in both community and in-home settings.

Transitional Facilities/Group Home Models

[redacted] provides a wide range of supports for individuals with special needs who require up to 24 hour care in a group home/transitional care facility or supportive living residence. [redacted] provides the care services in these homes to support individuals with disabilities. [redacted] has more than 120 transitional and group home facilities in operation within Canada.

Sample Service Delivery Models:

Service Delivery Model	Description
HOME FIRST: RAPID REHABILITATION AND REABLEMENT:	• Delivery of enhanced rehabilitation and re-enablement for seniors in their home to recover from illness and injury, return home faster following a hospital stay, minimize disability, decrease ER visits and prevent hospital admission and/or premature admission to LTC.
COMMUNITY NEURO SERVICES:	• Home and community based program providing integrated, case-managed, rehabilitation services for patients recovering from brain dysfunction including ABI and stroke. The program is based on a holistic, person-centred approach to rehabilitation and developed with the client's family/support system in mind, with the ultimate goal of reintegrating the patient into the community.
NEIGHBOURHOOD CARE TEAM:	• Dedicated interdisciplinary health care providers working together to provide support services for clients and their families; services are delivered in blocks of time based on individual care plans, allowing for more client touch points through a consistent team approach. This model improves continuity of care, strengthens social support networks, improves staff and caregiver experience; increases capacity to provide care to more clients in a cost effective way and leverages resources by fostering connections to community partners and neighbourhood resources.
TECHNOLOGY BASED MODELS OF CARE:	[redacted] looks to draw on emerging technologies to enhance the patient, family and caregiver experience. • [redacted] utilizes remote patient monitoring technology to optimize the management and treatment of seniors who are living with chronic disease(s). Leveraging wireless technology and monitoring devices to

[redacted]

	remotely connect patients to a registered nurse who monitors, assess and manages their vital signs. Our model allows for medication compliance while providing assessment of vital signs (blood pressure, pulse, blood glucose, weight, blood oxygen). Our outcomes have shown that our machine learning algorithms correctly predict 82% of events and care workers could prevent more than 70% of hospital readmissions and ER visits. • [redacted] has developed its own proprietary system [redacted] including a Clinical Mobile Application. [redacted] provides our clinicians with point of care access to appropriate clinical tools kits, a complete [redacted] client record, including [redacted] service history and all active [redacted] services and schedules. Our Clinical Care Tool Kits guide our clinicians through assessment selection, treatment and care planning designed to align clinical best practice with client goals and service agreements. The [redacted] (a tablet based application) provides our clinicians with efficient point of care charting, and decision support to ensure adoption of clinical best practice. • [redacted] is currently piloting other technologies such as activity monitors, heart rate monitors, exercise tracking software, on-line resource libraries and forms for exercise guidance and video based group sessions for education and/or exercise.

[redacted] is prepared to provide the following components in the development and management of the HCB and work in collaboration with other partners in implementing the UPCC:

* Capital investment to build or modify existing space
* Overall project management including oversight of infrastructure development
* Development and implementation of a technology framework that includes an integrated electronic medical record and telehealth services
* Provision of an integrated health care team that can include nurse practitioners (NP), nurses, physicians, specialists and allied health professionals
* Organizational leadership that promotes collaboration and communication between health professionals
* Provision and/or coordination of various clinical services that could include but are not limited to the following:
    - Physician practice management
    - NP led case management services
    - Nursing services including nursing clinics and complex wound care
    - Telehealth services including remote health monitoring
    - Full scope of home health services
    - Pharmaceutical and medical management/monitoring services
    - Dialysis
    - Infusion
    - Rapid rehabilitation and re-enablement services
    - Behavioral therapy services
    - Chronic disease management
    - Mental health services
    - Health system navigational services

[redacted]

- Outpatient rehabilitation services
- Hospice and palliative care
- Specialty Clinics (e.g. orthopedics, neuro, rheumatology, gerontology, etc.)
- On-site lab and x-ray services
- Transitional/short term residential care services

* Overall management of the Primary Care Home

A combined HCH with UPCC allows for a complete clinical community that meets the health and social needs of a specific population through a multi-specialty community provider model. [redacted] represents a number of community health segments, which puts us in a unique position to bundle and coordinate new, innovative services across verticals to better represent a full continuum of care.

[redacted] would provide an environment for better-coordinated care ensuring that patients receive comprehensive, high quality care and services that focus on health promotion and disease prevention and improve overall patient experience.

High level objectives and components of the model include but are not limited to the following:

* Whole person orientation: A focus on patient-centered care with improvements in population health outcomes
* Co-location of primary, community and social care services that address longitudinal health care needs of a defined population and decrease hospital visits, number of admissions and re-admissions and utilization of the acute care system on the whole
* 24/7 access to care: Commitment to enhancing patients' access to care and providing appropriate care at the right time, in the right place by the right provider(s).
* Standardized intake and assessment processes
* Provision of effective, proactive care planning and care coordination and rapid mobilization of services
* Telehealth to improve access to services and chronic disease management
* Electronic medical records to improve flow of information across the continuum of care
* Integrated Care: Provision of appropriate skill mix of health providers to meet primary health, community and social care including: Family Physicians, NP, Specialists, , Community Care Nurses, Community Paramedics, Pharmacists, Allied Health staff, Home Health Support staff, Social Workers

Space Required

[redacted] would sublease the space from VCH. Within the VCH boundary leases typically start at $28 per sqft + triple net costs on a 10 year term. [redacted] anticipates it would require around 10,000 to 15,000 sq ft.