

Integrated Primary and Community Care (IPCC) is a province-wide effort to coordinate GPs and community care providers, focusing on people with complex needs or high risk of admission. By collaborating and coordinating, we can improve care and optimize resources.

### North Shore IPCC Overview

- Objective**
- Comprehensive services for people with complex and chronic health issues
  - Patient-centered - GPs working more closely with community care providers can provide better delivery of services.
  - Improve quality of life, prevent disease and needless admissions.

- Patient Populations**
- Patients with chronic, co-morbid or complex medical needs
  - Patients with moderate to severe mental illnesses and/or substance abuse.
  - Fragile elderly.

### Activities and Initiatives

- Case Conferencing**
- Some Home & Community Care (H&CC) case managers and GPs have done telephone case conferencing.
  - Currently evaluating the effectiveness.
  - Hope to have all H&CC health disciplines engage in case conferencing with GPs, as appropriate,

- Intake Redesign**
- Improve the intake and processing of referrals
  - In June, GPs, H&CC staff, and community partners participated in Current and Future State Mapping sessions, facilitated by a Lean Specialist and Regional IPCC team.
  - Areas of for improvement have been identified and will be addressed.

- Complex Care Program**
- GPs can refer complex patients to Princeton Huang, Chronic Disease Nurse Coordinator, based at West Van Community Health Centre. ([Princeton.huang@vch.ca](mailto:Princeton.huang@vch.ca) 604.813.6481)
  - Includes physical assessment, med reconciliation, review of social needs, education, self-management support, and communication with GP after visits
  - Steady increases in GP referrals: 14 GPs participated and 39 clients to date.
  - A [video](#) explaining the chronic care navigator role has been well received due to its brevity and humour - and cameos by well known local health care professionals.