HealthLinks

Regional Update

Fall 2014

Inside This Issue

Upcoming Events

- 7th Primary Health Care Forum
  October 9th, 2014 — 8am –4 pm
- CSAH - Annual Conference
  October 23 & 24, 2014

Health Links are Changing the Way Care is Delivered: *Colette's Story*

by: Quinte Health Link

A cultural change is quietly transforming how care is being delivered across Ontario and in the South East, forging a new climate of collaboration. Health Links, which was announced in the latter part of 2012 by the Ministry of Health and Long-Term Care, has fostered new relationships across the Health Care sector, with one common goal in mind; 'A Better Patient Experience.'

Enter Colette. Up until three years ago, Colette's encounters with her family physician were nothing more than a check box, ticked off to ensure she could continue with her regular trips to see friends and family in Belgium. She was cheerful, happy and 73 years-young when the sudden discovery of a cancerous tumour in her leg in 2010 turned things upside down.

The next two years would test Colette's strength and spirit as her calendar – once filled with vacation plans – was taken over by intense radiation, surgery appointments, and daily visits from her Personal Support Worker (PSW). The tumour was invasive, and despite multiple surgeries to remove it, Colette eventually suffered the loss of her leg. An event that she notes took more of a toll on her family than her. 'I was suffering physically but my mind was not always there,' she explained.

(Continued on page 3)

Working Closer Together: *Meet the South East Health Links*

Since their creation, in December 2012, Health Links have proven to be an innovative approach to coordinate local health care resources to better and more quickly provide care to high-needs patients. Many, but not all, of these patients are seniors and others with complex conditions receiving care from several different providers; they represent five per cent of patients who account for two-thirds of health care costs in Ontario. Through Health Links, these patients will receive an individualized comprehensive care plan developed in partnership with their care providers and family. With this improved coordination and information sharing, Health Links enable the patient to receive efficient and more effective care, while being supported by a team of health care providers at all levels of the health care system.

Today, there are forty-seven community Health Links implementing this patient-centered model and transforming Ontario's health care system, with seven that span the entire South East LHIN geography. The catchment areas of the South East LHIN Health Links cover the southeastern region and a small portion of the Champlain LHIN.

Five of the Health Links were implemented in 2013-2014 and two Health Links, the Rideau Tay Health Link and Salmon River Health Link, have submitted their business plans to the Ministry of Health and Long-Term Care (MOHLTC) with final approval still pending.

(Continued on page 2)

Ontario

Meet the South East Health Links

(Continued from page 1)

Each of the South East Health Link has a designated Lead Organization that plays an administrative and coordinating role. To achieve their goals, each Health Link is working collaboratively with multiple partners from all health care sectors such as: local hospital(s) in the Health Link, the Community Care Access Centre, Community Support Services, Addictions and Mental Health, Primary Care, volunteer organizations, Hospice Palliative Care, Long Term Care, Public Health and others. Here are some examples of the priority areas in each of the South East Health Links.

Kingston Health Link (KHL)

KHL is currently implementing coordinated care planning across several organizations; developing a rapid access clinic for KHL complex patients at the Hotel Dieu Hospital; and addressing how to "attach" patients who are in need of a primary care provider. The Lead Organization for the KHL is the **Maple Family Health Team.**

Quinte Health Link (QHL)

QHL is actively implementing the Congestive Heart Failure Clinic in Belleville as well as coordinated care planning in several primary care organizations; and involving patients in the development of Health Links. The Lead Organization for the QHL is **Belleville and Quinte West Community Health Centre**.

Rideau Tay Health Link (RTHL)

While awaiting final MOHLTC approval of their business plan, the RTHL is proceeding with early development activities including initiating the design of a model for care coordination. The Lead Organization for the RTHL is **Rideau Community Health Services**.

Rural Hastings Health Link (RHHL)

RHHL is now developing a system navigator role (nurses) within 4 primary care sites to lead coordinated care planning with complex patients; mapping out critical pathways, resources and communication to optimize support for palliative and end of life patients; and improving access to real time patient information between primary care and the hospital to enhance the flow of patient care. The Lead Organization for the RHHL is **Gateway Community Health Centre**.

Rural Kingston Health Link (RKHL)

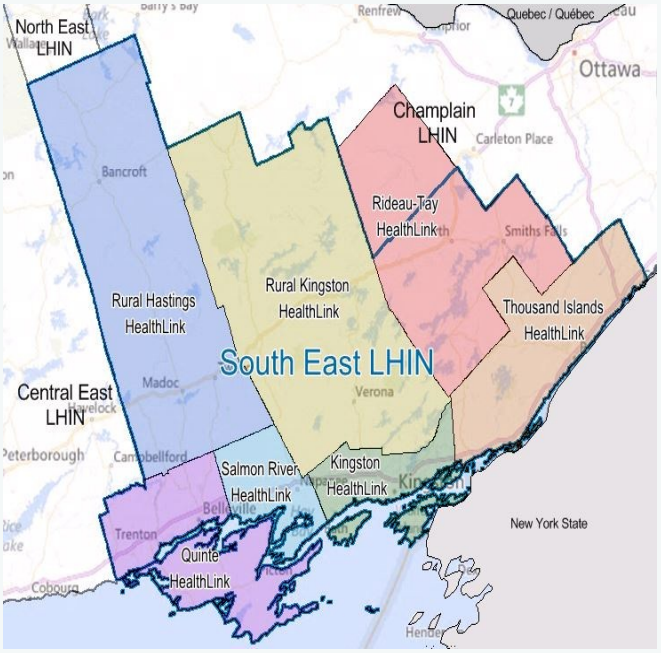
RKHL is currently implementing coordinated care planning across the area which involves various providers for different complex patient populations and identifying patients with complex mental health needs and implementing coordinated care plans for those with dementia. RKHL is also implementing a cardiology clinic. The Lead Organization for the RKHL is the **Rural Kingston Family Health Organization.**

Salmon River Health Link (SRHL)

While awaiting final MOHLTC approval of their business plan, the SRHL is proceeding with early development activities including the identification of complex patients for initiating care coordination. The Lead Organization for the SRHL is the **Napanee and Area Community Health Centre,** a satellite of the Kingston Community Health Centres.

Thousand Islands Health Link (TIHL)

TIHL is focusing on specific priority populations (i.e., Addictions and Mental Health; congestive heart failure) to test and refine the coordinated care process; implementing the Heart Function Clinic in Brockville; and trialing a care coordinator role (social worker) within the hospital setting to link complex patients to various providers. The Lead Organization of the TIHL is the **Upper Canada Family Health Team**.



Catchment of each Health Link within the South East LHIN

The **contact information** of the lead organizations and project managers of each Health Link are available on the last page.

Colette's Story

(Continued from page 1)

Through the trenches and out the other side, Colette was once again living independently at home, but a routine exam a year-and-a-half later would reveal a second tumour in Colette's lung. Courses of chemotherapy would leave Colette weak with heart failure and kidney impairment causing more frequent admissions to hospital..

During her hospitalization in January of 2014, Colette was introduced to Dr. Iris Noland, a partner with the Quinte Health Link, who spoke to her about the Health Links approach to coordinated care 'I really felt that she was taking care of me, and that she truly cared about what was important to me,' says Colette as she reflects back on her first interactions with Noland.

Together, with local Health Link project manager, Mary Woodman, Noland began what is called the 'care planning process. Simply put, it is learning about Colette; her family, health conditions, care, providers, needs, and her dream of once again returning to Belgium.

'By giving the patient a voice, health care providers are able to gain meaningful information about what matters to the patient leading to more tailored care plans and greater patient experience,' says Woodman. 'The focus is no longer just on medical disease but rather the patient, including their values and wishes. This is central to the Health Links approach.'

Did you know ?

7 Health Links cover the entire South East LHIN geography and a small portion of the Champlain LHIN

7 primary care organizations in the South East LHIN have taken on the role of Lead Organization for their respective Health Link. A Lead Organization plays an administrative and coordinating role to support a Health Link.

314 coordinated care plans for complex patients were implemented by the Health Links since December 2013.

Between April and June 2014, the Health Links implemented coordinated care for **120** complex patients .

Each decision within the coordinated care plan is weighted based on its capacity to bring the patient closer to his or her goals. With Colette, Noland explains, she is now at the helm, driving her way through the system and is involved in and making important decisions about her care. 'My role is now more of a navigator, where I am giving her all the information I hold so she can make informed decisions about the direction she would like her care to go,' says Noland.

In Colette's plan, it was a decision to pause her chemotherapy treatments, to enable her to return to Belgium.

'Sometimes, doctors have the right answers to the wrong questions, trying to treat the disease rather than the person. To deliver real patient centered care we need to enhance the patient experience,' says Woodman.

Today, Colette is involved with Woodman and Noland to inform providers and the public about the difference the Health Links approach has made in her journey. For Woodman and Noland the goal is to change the mindset of providers, moving from 'What is the matter?' to 'What matters most to you?'

For Colette, that answer is found in the patient-centered care she is receiving with the Quinte Health Link model, and of course a round-trip ticket to Belgium this summer.

Boarding the SHIIP

What is SHIIP?

The South East Health Integrated Information Portal or SHIIP is an information tool that connects and summarizes information from multiple clinical and administrative data sources within the South East healthcare system.

SHIIP
SOUTH EAST HEALTH INTEGRATED INFORMATION PORTAL

SHIIP is designed to support Health Links initiatives by identifying and assisting in the delivery of care to patients with complex health conditions requiring on-going health care support including those who are at a high risk of hospital readmission or have a history of repeat visits to health care providers.

Why it is so important

As a technology enabler, SHIIP will support collaborative, multi-agency care processes such as clinical management and care

(Continued on page 4)

Boarding the SHIIP

(Continued from page 3)

coordination for patients. SHIIP will also provide clinicians with electronic access to real-time and historic views of patient information at the point of care. Using this tool, clinicians will be able to quickly access key information and identify complex/high needs patients enabling improved quality of care.

Where is SHIIP Today?

In preparation for pilot phase, a prototype of SHIIP is now being built by Kingston Frontenac Lennox & Addington (KLF&A) Public Health with the collaboration of Kingston General Hospital (KGH), Brockville General Hospital (BGH) and the South East LHIN IT leads.

This pilot phase will allow sharing of patient information from KGH to two primary care sites, Maple Family Health Team and Kingston Community Health Centres, using data from the Admission, Discharge and Triage (ADT), National Ambulatory Care Reporting System (NACRS) and Discharge Abstract Database (DAD). In its pilot phase, SHIIP will create a one way communication stream where information will flow from the hospital to primary care providers.

SHIIP pilot is expected to be launched in the third quarter of 2014/15. As the sponsor of the project, the South East LHIN coordinates and supports the ongoing activities of the following work streams:

- Project Management and Governance
- Technical Infrastructure and Build
- Privacy/Legal Framework Development
- Change Management Planning (Workflow Analysis/Quality Improvement, Stakeholder Engagement, Evaluation, Training & Education, and Communication).

Interested in learning more about SHIIP?

For further information or documentation regarding SHIIP, please contact

Gina Johar at gina.johar@lhins.on.ca or **Michael Spinks** at michael.spinks@lhins.on.ca

Upcoming Events

South East LHIN Primary Health Care Forum

October 9, 2014 — 8 m-4pm

The South East LHIN is proud to host the 7th Primary Health Care Forum at the Ambassador Hotel in Kingston. This year the theme of the Forum is "*Seeing the Big Picture: Social Determinants of Health and Health Links*". *Check out* this year agenda, the presenters and the workshops by visiting the Forum's website page and join other health care providers, for a day of learning and networking.

Few spots are still available. **Register Now!**

CSAH - Annual Conference

October 24, 2014 — 8 m-4pm

You are invited to gather and share experiences and knowledge around emerging hot topics related to senior care at the Centre for Studies in Aging & Health Annual Conference held at the Portsmouth Olympic Harbour in Kingston. Get more information the CSAH Annual conference and register here.

CSAH - Community Open House

October 23, 2014 — 5 pm-7 pm.

In addition to the Geriatrics 20/20 Conference, CSAH is also holding a poster and photo exhibition at a community event at Portsmouth Olympic Harbour. Learn more about the Geriatrics 20/20 by downloading the CSAH Annual Conference Information Package (PDF).

Health Links Contacts

Kingston Health Link (KHL)
Lead Organization contact: Marg Alden
613-531-5888 ext 103
Project Coordinator: Linda Robb-Blenderman
613-453-0361

Quinte Health Link (QHL)
Lead Organization contact: Marsha Stephen
613-962-0000 ext 203
Project Coordinator: Mary Woodman
613-539-6061

Rideau Tay Health Link (RTHL)
Lead Organization contact: Peter McKenna
613-269-3400 ext. 224
Project Coordinator: Maureen McIntyre
613-283-0001

Rural Hastings Health Link (RHHL)
Lead Organization contact: Lyn Linton
613-478-1211
Project Coordinator: Allan Chong
613-478-1211 ext. 246

Rural Kingston Health Link (RKHL)
Lead Organization contact: Lynn Wilson
613-374-3311
Project Coordinator: Lynn Wilson

Salmon River Health Link (SRHL)
Lead Organization contact: Hersh Sehdev
613-542-2949, ext. 1145
Project Coordinator: Meghan O'Leary
613-354-8937 ext. 151

Thousand Islands Health Link (TIHL)
Lead Organization contact: Sherri Hudson
613-423-3333 ext. 222
Project Coordinator: Sherri Hudson