LET'S MAKE HEALTHY CHANGE

Kingston Health Link Bulletin

February 2014

What are Health Links?

[1] Health Links are a new way of coordinating local health care for patients who often receive uncoordinated care from several different providers, resulting in both gaps and duplication in the care provided.

[2] Family care providers are at the centre of the health care system. Health Links will help family doctors to connect patients more quickly with specialists, home care services and other community supports, including mental health services.

[3] For patients being discharged from hospital, the Health Link will allow for faster follow-up and referral to services like home care, helping reduce the likelihood of re-admission to hospital.

[1, 2, 3] http://www.southeastlhin.on.ca

[4] Holistic health care - "a system of comprehensive or total patient care that considers the physical, emotional, social, economic, and spiritual needs of the person; his or her response to illness; and the effect of the illness on the ability to meet self-care needs".

[5] Transitions of Care - "a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location."

[6] Care Coordination – "the deliberate organization of patient care activities and other resources to carry the exchange of information amongst health care providers and the patient / family, to facilitate the appropriate delivery of health care services."

[4] Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier;
[5, 6] http://www.ntocc.org/Portals/0/PDF/Resources/TransitionsOfCare_Measures.pdf)

Introduction:

In Sept. 2013, senior leadership from 13 local partner organizations endorsed a "systems model of care" embedded in Primary Care for the holistic health care[4] management of medically complex patients. The organizations represented the 131 Family Physicians within Primary Care working with Kingston Hospitals and Community Services to form the Kingston Health Link (KHL).

Steering Committee:

To operationalize the KHL model, a smaller working group was formed, called the Steering Committee, and it is being chaired by primary care physician, Dr. Veronica Mohr. The Steering Committee is working on three main initiatives:

1. Unattached patients – the goal of this project is to reduce unattached patients by 90% in Kingston. Currently there are over 600 in Kingston on Health Care Connects waiting list. Richard Christie, Executive Director, Kingston FHT, is chairing a working group to develop a process for reducing this number. The group is working closely with Health Care Connect.
2. HDH Rapid Access Specialist Clinics – the goal of this project is to reduce ED visits for complex patients through better access and communication between Specialist clinics, Primary Care and other sectors. An implementation plan is being developed.
3. Implementation of a systems model of care for complex patients – the goal of this project is to improve the transitions of care[2] and coordination of care[3] (continuity of care and communication) between all healthcare partners to improve the patient experience and reduce unnecessary hospital visits. The Steering Committee has been working on testing the model through interviews with complex care patients as identified by the KGH/HDH Emergency Department/In Patient Admissions database. The KHL hired Linda Robb Blenderman RN, as the first Complex Care RN in Primary Care, and her initial task was to conduct 10 patient interviews. This proved more time consuming than previously thought due to the need to work though privacy and consent matters at each primary care organization.

Patients and Caregivers Stories:

Eight patient stories were presented to the KHL Steering Committee on Jan. 24, 2014. While there were compliments about caring providers and organizations, *the following themes were identified as areas requiring our attention:*

- Holistic health care[4] including mental health, addictions, palliative & end of life
- Screening for distress in primary care e.g. anxiety, depression, caregiver fatigue
- Transition of care[5] between specialist services and sectors is inconsistent.
- Coordination of care[6] or "who is coordinating my care"

Next Steps:

- A patient journey day is being planned for Feb 21st. A small group of heath care providers will spend a day reviewing patient stories to develop better care pathways and patient management strategies between organizations and sectors.
- The results from the patient journey day will be presented to the Stakeholders Committee at a meeting to be set in March 2014.

FOR MORE INFORMATION ON THE KINGSTON HEALTH LINK CONTACT MARG ALDEN: malden@maplefht.ca