THE LINK

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HealthLink
Rural Hastings Health Link
Let's make healthy change happen

SEPTEMBER 2014

RHHL Vision Statement

"We will improve the health in our communities. We will provide care in partnership with providers, patients, and their families to achieve better health. Together, we will create a system that enables, promotes ownership and improves health through engagement, leadership, innovation, and education."

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RURAL HASTINGS HEALTHLINK– Our Approach

Rural Hastings HealthLink (RHHL) is one of seven HealthLinks within the South East LHIN (SE LHIN) and is an early adopter of the HealthLink initiative in Ontario. RHHL is comprised of four Primary Care Organizations: Gateway Community Health Centre, Central Hastings Family Health Team, North Hastings Family Health Team, and Bancroft Family Health Team, as well as community partners supporting Central and North Hastings. RHHL champions a new systems approach supported by innovative thinking and creative methods that will create the opportunity for health system transformation, improve the patient's experience, optimize health outcomes, and decrease costs to the system as a whole. A systems approach to support patient engagement, and enhance the patient/family experience requires looking at new ways for the patient, the Health Care Providers, community service providers, and organizations to provide services in an integrated way, while maintaining the autonomy and integrity of our respective organizations. Working together, we are coordinating the care of the 1-5% of the most complex clients currently using the health care system.

RHHL experienced an 89% reduction in Emergency Department visits for complex patients who had their own Care Coordination Plan

RHHL experienced an 86% reduction in hospital admissions of complex patients who had their own Care Coordination Plan

To date, RHHL has completed 108 Care Coordination Plans (CCPs)

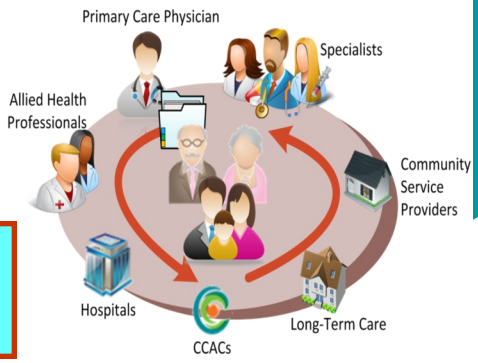
Identifying Complex Clients

- 3 or more visits to the Emergency Department in the past year
- 2 or more hospital admissions in the past year
- 5 or more prescribed medications
- 2 or more co-morbidities
- Palliative or End Of Life

CARE COORDINATION PLANS– The Patient's Perspective

The Care Coordination Plan is developed from the patient's perspective, to identify their personal health goals and priorities. It shifts and expands the conversation to the patient, while engaging the provider. The Care Coordination Plan integrates the patient's goals with the medical and service plan of care. The Care Coordination Plan brings all service providers together with the patient and their family to offer a truly patient–centred experience.

Ask your System Navigator how you can participate.



How System Navigators can support You

- *Identify complex patients*
- *Collaborate with Primary Care Providers*
- *Act as a liaison between transition points of care: i.e. home and service supports*
- *Follow up with patients recently discharged from hospital*
- *Facilitate shared care planning*
- *Be a conduit between Primary Care Providers and our broader sector partners participating in the patient's plan of care*
- *Monitor and evaluate the patient's care coordination plan against expected outcomes*
- *Create spread across the continuum of care by engaging Providers in the CCP process*

Meet with your DMC today.

DMCs -Supporting Primary Care Providers in:

- Data integrity
- Data discipline
- Data analysis
- Measuring success using performance indicators

SYSTEM NAVIGATION — How can we help you?

System Navigators are Registered Nurses who support complex patients and their health care Providers through a Care Coordination Plan. The plan may include: nursing assessment, medication review, monitoring of referrals to the patient's primary care Physician or Nurse Practitioner, and/or Pharmacist for medication reconciliation, and initiating internal/external referrals for the right services at the right time. In collaboration with the patient and their family, System Navigators identify socio-economic factors and barriers to achieving personal health goals. They also identify, track, monitor, and evaluate plan of care outcomes and align the plan of care in collaboration with the patient and/or family.

Meet with your System Navigator today to learn more.

Supporting the primary care sites within RHHL, the System Navigator Team is pictured here. From left to right; ***Matt Tomasini RN-*** *Central Hastings FHT,* ***Erica Farrell RN*** *-North Hastings FHT,* ***Emily Rashotte RN****-Gateway CHC, and* ***Christina Hoye-RN****-Bancroft FHT*

DID YOU KNOW...

System Navigation is one of only 35 **Medically Complex Patient Pilot Projects** supported by the **Ontario Ministry of Health and Long-Term Care** and the **OMA**. These projects are led by primary care physicians and were chosen for their specific design and their potential to improve health outcomes, prevent hospital admissions and readmissions, and improve the experience of the medically complex patients within our healthcare system. GCHC's Dr. Andy Quinn leads the RHHL MCDP project that will be evaluated through **Bridges** evaluation framework.

DATA MANAGEMENT— Supporting Decisions Through Evidence

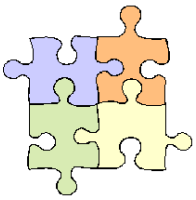
Data Management Coordinators (DMCs) are embedded in each primary care site to support the Primary Care Team through data integrity, data discipline, and collecting the information against established performance indicators. Data is fundamental in planning, alignment, evaluation, and reporting. Data tells the story and helps to keep us on track and identify areas of opportunity.

RHHL DMCs: ***Alicia McCullam*** *(left) for Central Hastings FHT,* ***Gwen Montroy*** *(center) for Bancroft FHT and* ***Angela Holbrook*** *(right) for North Hastings FHT.*

Each DMC supports their respective Physicians/Nurse Practitioners and System Navigators through timely data and information support that identifies potential complex patients, ensures data discipline, data accuracy and precision, as well as providing data for provincial and HealthLinks reporting. All DMCs are also members of the RHHL Data Quality & Privacy Working Group.

All physicians within the Rural Hastings HealthLink are now able to work with the DMCs to receive real-time data from Quinte Health Care regarding hospital admissions/discharges and Emergency Department visits. Access to real-time data supports providers in identifying and analyzing Complex Patients to mitigate unnecessary Emergency Department utilization, and in tracking patient discharge from hospital.

RHHL WORKING GROUPS– Creating Change



Working Groups are comprised of service providers from our primary care partners and our broader health system partners. Each individual brings a working knowledge from their own organization and is committed to informing others, system planning, and identifying barriers, as well as new opportunities to re-design systems and care pathways.

They engage one another and share professional experience in order to integrate the patient and family experience, and to exact change at key transition points of care where patient, family, and providers meet.

Improving information transfer between those who provide the service, those who receive the service, and the Primary Care Provider Team supports our collective goal for a seamless system.

All working groups utilize improvement methodologies such as: Improving and Driving Excellence Across Sectors (IDEAS) Project Methodology, Process Mapping, CQI, and the Triple Aim framework to guide their discussions. Currently, working groups are focused on identifying opportunities for improved system integration that support system re-design.

SE LHIN PRIMARY CARE FORUM– October 9

RHHL is presenting at the SELHIN Health Care Forum on October 9, 2014 in Kingston, Ontario. Entitled "The Role of System Navigation within Primary Health Care: Addressing Social Determinants of Health," the presentation will be given by Dr. Adam Stewart, Angela Holbrook, DMC, Matt Tomasini, System Navigator, Sandra McGrath, Executive Director– Bancroft FHT, and Allan Chong, RHHL, Project Manager. The format is a brief introduction of the demographic profile of RHHL, followed by a description of the RHHL system navigation model, and finally a panel discussion of a patient's journey and the impact of system navigation on the determinants of health.

Register at www.southeastlhin.on.ca

LEARN MORE…

To learn more about Rural Hastings HealthLink initiatives, or to book a presentation for your Primary Care Team, or organization, please contact:
Allan Chong, RHHL Project Manager.
Telephone: 613-478-1211
Email: achong@gatewaychc.org

END of LIFE-PALLIATIVE CARE WORKING GROUP

Using the IDEAS methodology, the group is mapping the patient journey, identifying system gaps and opportunities that will provide seamless transitions in care, focused on the right care at the right time and providing timely support to End of Life/Palliative Care Patients.

Janet Webb, MD
Cindy Brandt CC LTC
Donna Blakely, VON
Laurel Hoard, SELHIN
Donna Logan, CCAC
Maureen Chapman RPN
Olga Nikolajev, SELHIN
Trish McPherson, RN
Allan Chong, PM RHHL
Lysane Burnett, RT
Tammy Davis, QHC
Garry Laws, MHSN
Clarissa Townsend, NP
Kathy Plunkett, HCM
Emily Rashotte, RN

DATA QUALITY & PRIVACY WORKING GROUP

The current focus is on performance management and consistent, efficient, accurate, and timely data reporting.

- Established access for all RHHL physicians to receive real-time data on admissions and ER visits from Quinte Health Care Corporation.
- Developed standardized definitions for complex or priority patients and reporting of profiles of RHHL complex patients including social determinants of health.
- Created a process to track RHHL patients' plans of care within primary care Electronic Medical Records (EMRs) electronically.

Adam Stewart, MD
Julia Swedak, GCHC
Alicia McCullam, DMC
Sandra Taylor-Owen-FHTs
Gwen Montroy, DMC
Allan Chong, PM RHHL
Angela Holbrook, DMC
Simone Walters, CCAC

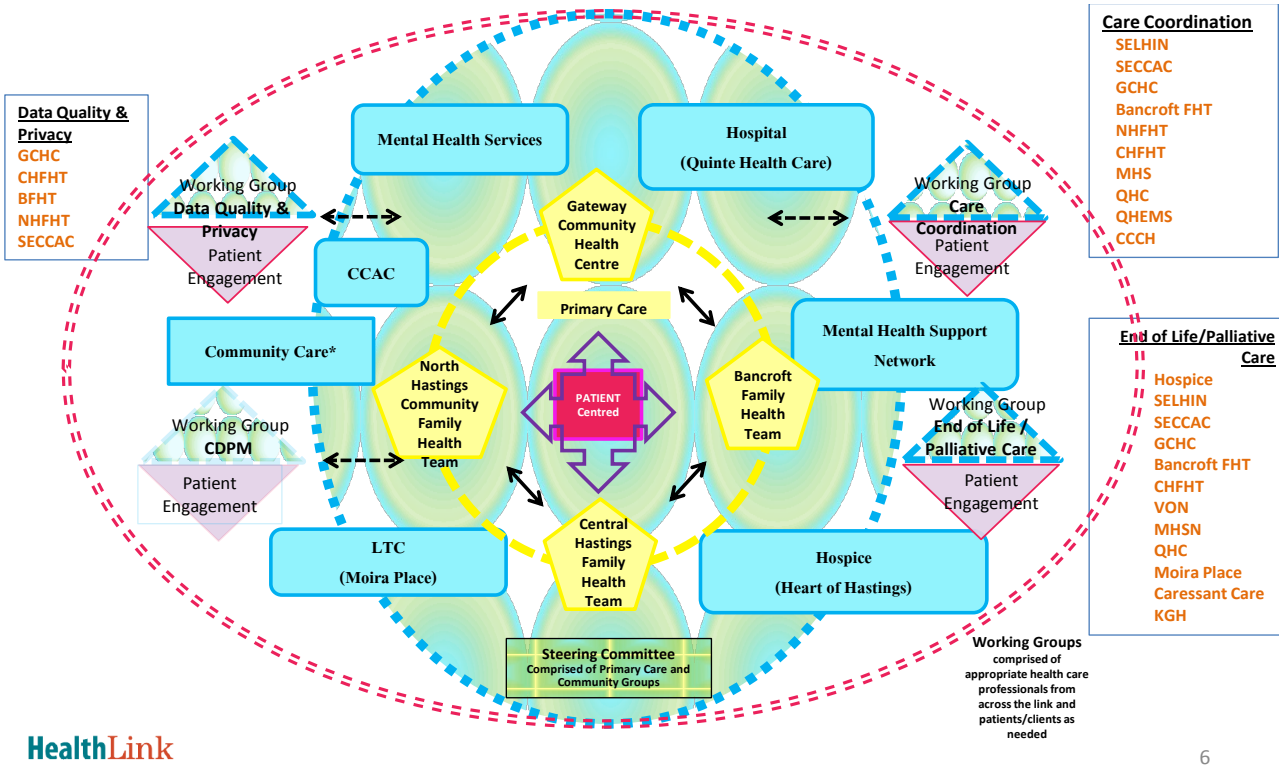
CARE COORDINATION WORKING GROUP

Process mapping for:

- Improving electronic information exchange between Primary Care and Community Support Services' (CSS) EMR system which will create access to RAI CHA assessments, sending and receiving referrals, and access to patient information through a secured electronic system.
- Access to primary health care services for mental health patients.

Allan Chong, PM, RHHL
Emily Rashotte, RN
Mary Grattan-Gielen, CCAC
Tammy Davis, QHC
Donna Ferguson, NP
Laurel Hoard, SELHIN
Julia Swedak, GCHC
Susan Blakely, NP
Cheryl Marks, NP
Christina Hoye, RN
Val Myles Gill CCCH
Paul Meadows, MHS
Roxina Keith, CCNH
Carl Bowker, QH EMS
Melissa Holowaty, MD

RURAL HASTINGS HEALTHLINK COALITION



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RURAL HASTINGS HEALTHLINK– STEERING COMMITTEE

Rural Hastings HealthLink
Allan Chong, Project Manager

Gateway CHC
Lyn Linton, Executive Director
Julia Swedak, Director of Quality and Decision Support
Emily Rashotte, RHHL System Navigator RN
Andy Quinn, Physician

Central Hastings FHT
Mary Stuart, Administrator
Adam Stewart, Physician
Janet Webb, Physician

North Hastings cFHT
Cathy Pearson, Executive Director
Cheryl Marks, Nurse Practitioner

Bancroft FHT
Sandra McGrath, Executive Director
Carolyn Brown, Physician

SE LHIN
Cheryl Chapman, Health Links Lead
Jonathan Kerr, Primary Care Lead
Laurel Hoard, Quality Improvement and Implementation Facilitator

Mental Health Support Network
Garry Laws, Executive Director

South East Community Care Access Centre
Mary Grattan Gielen, Senior Manager, Program Development

Mental Health Services
Paul Meadows, Executive Director

Quinte Health Care
Tammy Davis, Manager Patient Services, QHC North Hastings Hospital

Community Care Central Hastings
Pat Dobb, Executive Director

Community Care North Hastings
Roxina Keith, Manager Programs & Services, Executive Assistant

Moira Place LTC
Michael O'Keeffe, Administrator

Providence Care
Dr. Ken Le Clair, Regional Partnership and Development Coordinator and Academic Chair of Geriatric Psychiatry Providence Care

Heart of Hastings Hospice
Janet Webb, Physician