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Campbellford Memorial Hospital and Trent Hills Family Health Team Working Together to Ensure Senior Patients Receive Greater Access to Care

Campbellford Memorial Hospital and the Trent Hills Family Health team (THFHT) have received funding from the Central East Local Health Integration Network (Central East LHIN) Health Links Quality Improvement Fund to ensure more patients – largely seniors with more complex health care needs who now don't have access to primary care – have greater access to primary care close to home.

Currently the THFHT physicians have full practices and there is a waiting list of area residents requiring a primary care provider. Efforts to recruit an additional primary care physician to the THFHT are underway. Without an area walk-in clinic, patients without a primary care physician who are on the wait list have no alternative than to visit the Campbellford Memorial Hospital ER for their primary care.

"From June – December 2015, there were 1,775 ER visits from patients without access to primary care. Given the high percentage of seniors in our area, we anticipate that within that population, there are seniors and patients with complex needs," explains Brad Hilker, President & CEO, Campbellford Memorial Hospital.

Elderly and complex patients with multiple health concerns, including diabetes and respiratory issues, are particularly vulnerable to complications. When chronic diseases are well managed, complications may be prevented and minimized. Until a new primary care physician is recruited to the THFHT, Campbellford Memorial Hospital and THFHT are embarking on a trial project to match these complex care patients with a primary care provider.

The two organizations are piloting a system to identify frequent users of the Emergency Department and who don't currently have a primary physician. Supported by Health Links Quality Improvement funding, Campbellford Memorial Hospital will identify high use ER patients without a primary care physician to determine the scope of the problem.

A Health Links Coordinated Care Plan (CCP) will be created for each patient. The CCP is a care coordination tool that records the patient's care goals and the clinician's plans to deliver care based on those goals. The CCP will be made available to all members of the patient's health care team, including specialists, to allow clinicians to communicate more effectively and to ensure the patient receives the level of care they require from the appropriate health service provider.

"Across the Central East LHIN, patients, caregivers, health care providers and other partners are working together as Health Links networks to effectively identify every patient with complex health needs and improve their health outcomes. The LHIN is committed to supporting the evolution of these Health Links networks as it moves forward with advancing integrated systems of care to help Central East LHIN residents live healthier at home," said Deborah Hammons, CEO, Central East LHIN. "We are pleased to support Campbellford Memorial Hospital and the Trent Hills Family Health Team, two Health Link network organizations, as they work together to create Coordinated Care Plans for their shared patients and increase access to primary care in the Northumberland County community."

The goal of this Campbellford Memorial Hospital – THFHT pilot project fits perfectly with the Health Links philosophy: better care for complex and senior patients, few patients accessing ERs for conditions best managed by primary care, fewer unnecessary hospital admissions and ultimately, better use of our health care dollars.

This new initiative builds on and complements an existing arrangement that has Campbellford Memorial Hospital providing the Trent Hills Family Health Team with daily alerts about patients who are discharged from the hospital. Using this information, the Trent Hills Family Health Team proactively contacts the patient to book post hospital discharge appointments with a family physician. To date, more than 178 patients have been contacted through the system and the approach is reducing the number of repeat ED visits or hospital readmissions.

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For more information, please contact:
Delayne Donald, Executive Director
Trent Hills Family Health Team
E: deloa9@thfht.com; P: 705-653-1801

Or
Brad Hilker, President & CEO
Campbellford Memorial Hospital
E: bhilker@cmh.ca; P: 705-653-1140 ext. 2000