Benefits Realization Case Study: Health Links coordinated referral process results in efficient, appropriate care for patients in Cambridge-North Dumfries

Background

A well-planned, streamlined referral process can help to ensure that patients receive optimal care and service coordination that is tailored to their needs [1]. Evidence suggests that centralizing referral intake, developing a method of triaging patients, and screening to determine patient care needs can aid in achieving efficient, appropriate patient care and service coordination [1-3]. For example, the Alberta Health Network developed a multidisciplinary outpatient clinic, called Cardiac EASE, which utilized a single point of entry central intake and triage system to receive referrals for cardiac consultation [2]. For Cardiac EASE, a nurse practitioner in the clinic reviews all referrals and selects a cardiologist based on the patient's needs and the availability of appropriate cardiologists, a process which has improved the appropriateness of referrals and reduced wait times in the area [2].

The Cambridge-North Dumfries (CND) Health Link is one example of a team in Ontario that has developed a referral process that incorporates these recommended elements for delivering efficient, appropriate patient care and service coordination. They have developed a central point of intake that streamlines the process by triaging patients based on urgency, and collecting as much information about the referral as possible in order to determine which services the patient should be connected to. The referral process involves Langs Community Health Centre (as the lead agency of the CND Health Link), the Waterloo Wellington Regional Coordination Centre (RCC), the Community Care Access Centre (CCAC) In-home Team, and Health Links System Navigators. Each team member plays an important role in connecting the patient with the right care, in the right place, at the right time.

Value proposition

The development of a coordinated referral process for complex patients to access services results in an efficient and streamlined referral process, and appropriate service coordination and care for patients.

79%

of providers surveyed who have referred patients or clients to Health Links would recommend it to a colleague.

"As the System Navigator, my role in the referral process can be dynamic. The vast majority of referrals received from Central Intake come from Physicians/Nurse Practitioners or community agencies. The Langs Administrative Assistant will send me referrals if they have been deemed appropriate for System Navigation. These referrals will come with the original Referral Form completed, often with addendums of information gathered from primary care or referral source, that highlight medical histories, social histories, and/or detailed concerns about present functioning. I will also connect with the referral source to determine if my understanding of the situation is in line with theirs, and if there is any particular information they think would benefit the relationship between the client and myself before I make first contact.

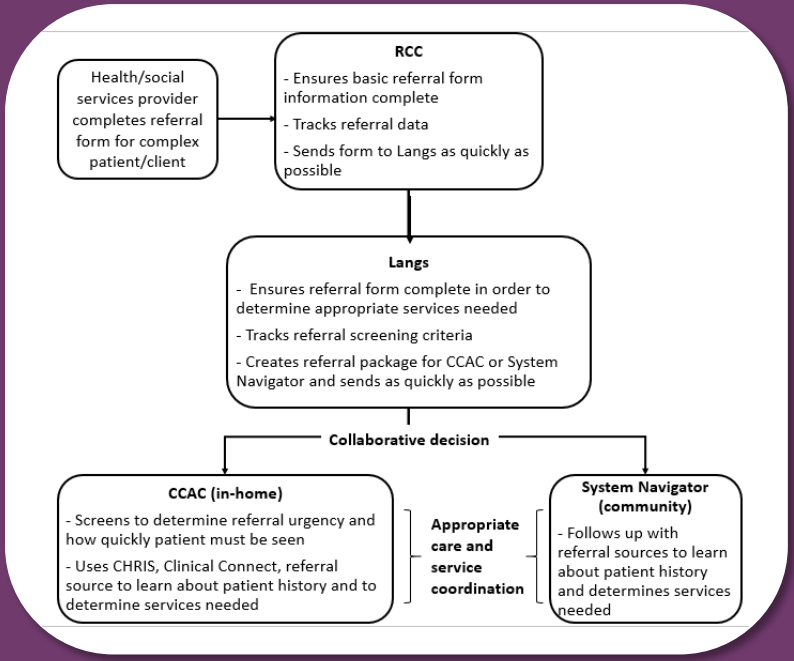
In my experience the referral process is a time for consultation and information sharing. In doing so, I can ensure my understanding is accurate and also learn in advance of any information that will make the introduction of myself into the client's life as seamless as possible."

- Krystal Kellington, System Navigator, CND Health Link

What were the Benefits?

When health or social service providers in Cambridge identify a complex patient or client who they feel may benefit from Health Links, they complete a referral form, which is received through central intake at the RCC. This streamlines the process so that all referrals are received in one place, avoiding duplication. RCC staff focus on making sure that forms are complete prior to sending them to the Langs Administrative Assistant (AA).

The Langs AA ensures they have the information needed to determine how to navigate the referral. They engage in a collaborative discussion with the Health Link manager to determine whether a patient will be referred to the CCAC In-home Team (in-home assessment and service coordination) or the Health Link System Navigator (community-based service coordination). The AA saves providers time by consolidating referral information into a concise package and sending it to the appropriate provider without delay.



The CCAC In-home Team and Health Link System Navigator provide care and service coordination tailored to the patient's needs. They also have methods of learning about patient history and determining the urgency of each referral. For example, the CCAC In-home Team uses CHRIS, ClinicalConnect,* and communication with the referral source to decide exactly what type of CCAC services are needed. They also use this information to assess the urgency of the referral and will immediately connect with patients who are deemed to be high priority, increasing the efficiency of care.

Program Details

Healthcare spending is highly concentrated: the top 1% and top 5% of health services users accounted for 34% and 66% respectively of health cost in Ontario in 2007/8 [4]. These high health care users are likely to be patients with complex care needs and/or multiple chronic conditions. The Ontario Ministry of Health and Long-Term Care recognized the need to better coordinate care for these most complex patients within the community in order to improve health outcomes and drive health system efficiencies, and thus initiated the Health Links approach to care in 2012.

The Waterloo Wellington Local Health Integration Network (WWLHIN) is in the process of conducting an evaluation of the Health Links approach to care within the region. The eHealth Centre of Excellence (eCE) has supported this evaluation by conducting a Benefits Realization (BR) study in each of the four sub-LHIN geographies within the WWLHIN. The eCE's work focused on the impact of the Health Links approach to care by conducting a pre-post Coordinated Care Plan (CCP) comparison of acute care use and developing clinical narratives to highlight the clinical value enabled through the Health Links approach. This BR case study is one of the outcomes of the eCE work.

Works Cited

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If you are interested in participating in a future BR case, please contact eCE BR Practice Lead Lori-Anne Huebner at: Lori-Anne.Huebner@eHealthCE.ca

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