HealthLinks

....plus over 30 other organizations spanning community social services, community health services, home care, government agencies and long-term care and more!

Our Philosophy:

Hear What Matters, Imagine What's Possible!

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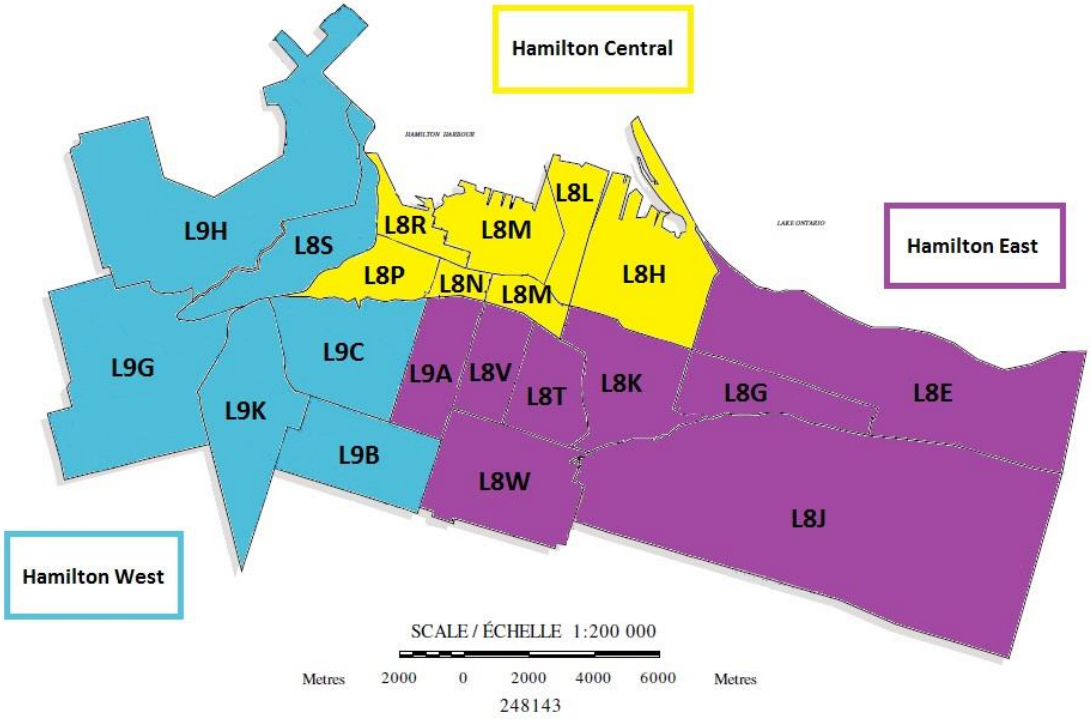
Health Links in Hamilton

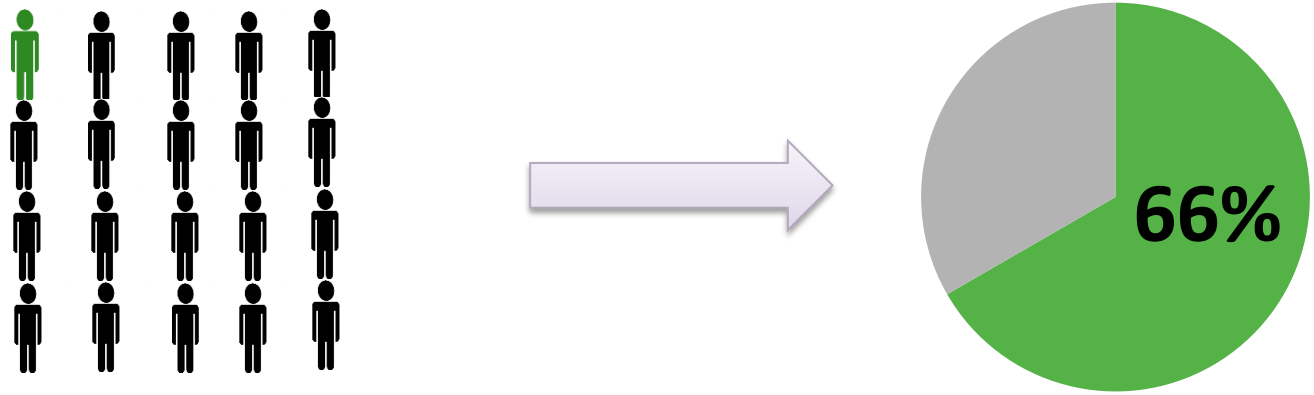


Each community is organized into Health Links so that **local** population health needs are met by **local** solutions.

The 3 Health Links in **Hamilton** are working together under shared leadership to serve our community.

Where do we start?

5% of the population accounts for 66% of total health care spending



- These citizens are the **most frequent users** of healthcare services but they are **not well served**
- Goal: **Improve the quality and experience** of care and contain rising costs.

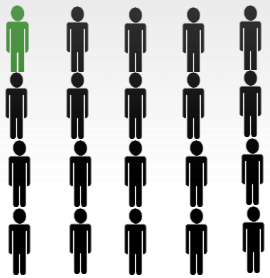
Where do we start?

1000 individuals in Hamilton represent the top 5% of ED use and hospitalizations

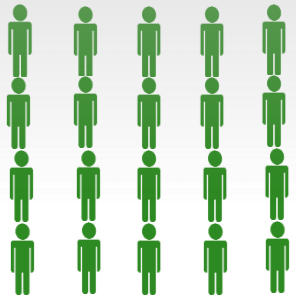
Major diagnoses include; COPD, Heart Failure, Diabetes

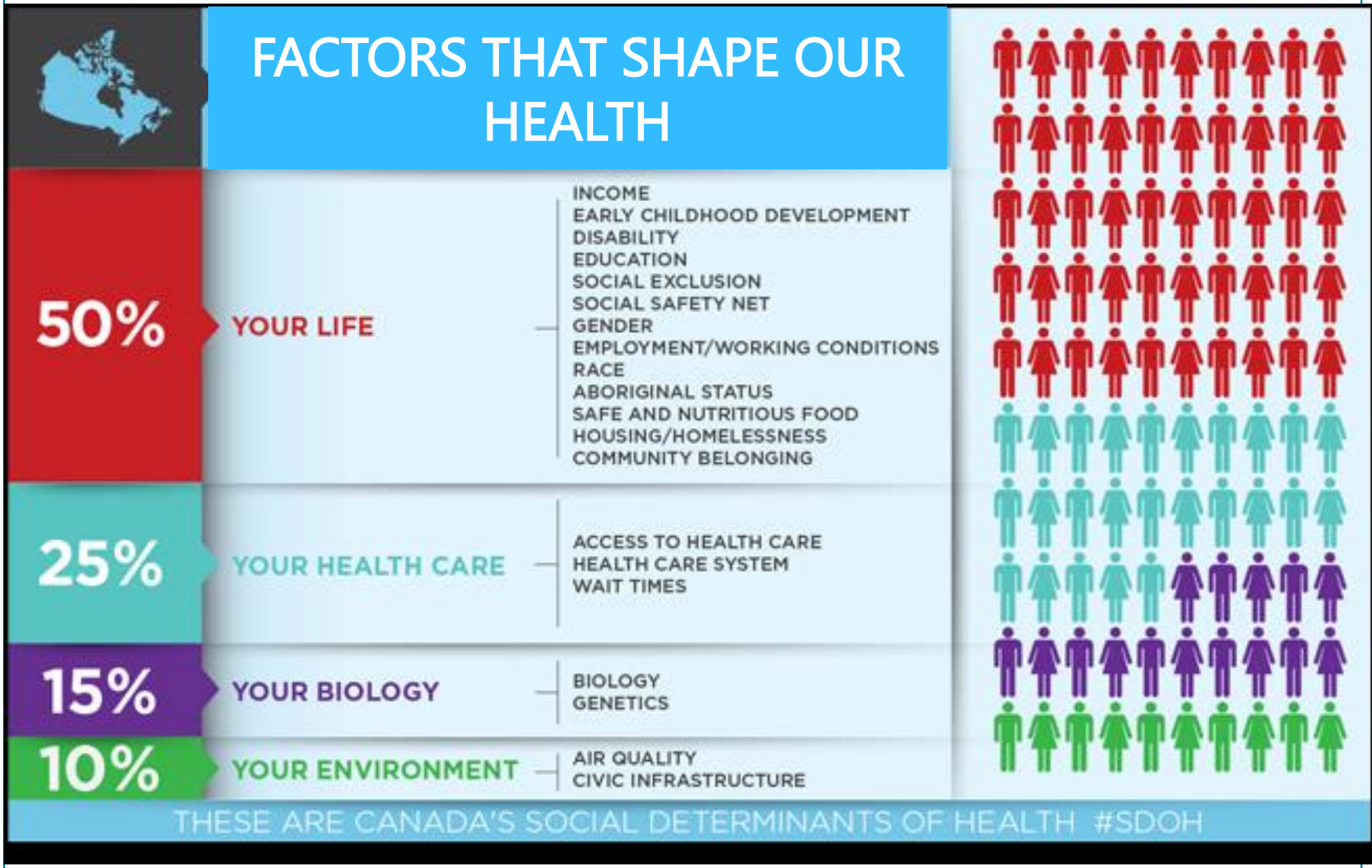
60% are over the age of 65

Individuals with addictions, mental illness

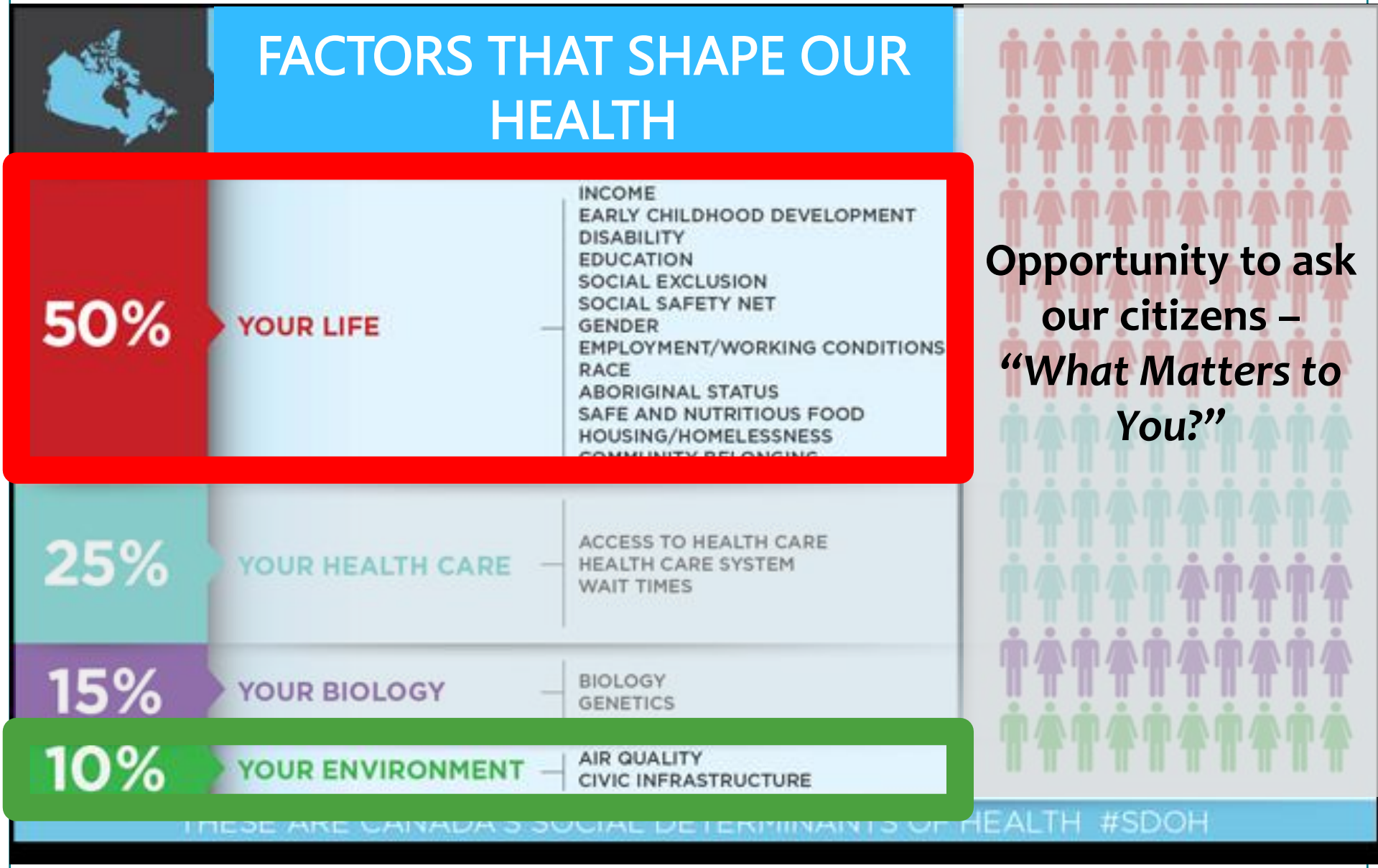


Learn from the 5% , make changes that impact the population





Source: Canadian Medical Association. www.cma.org



Opportunity to ask our citizens – *"What Matters to You?"*

Source: Canadian Medical Association. www.cma.org

Frances

Frances values accessibility and had difficulty accessing the employment insurance office following her leg amputation.

Guiding Principle: Citizens will be healthier with appropriate housing, income and social support.

John

John values equality. He struggled to find a family doctor comfortable treating him because of his complex health issues and his past narcotic use.

Guiding Principle: Citizens will be healthier with access to appropriate health services.

Tara

Tara values her own health so that she can support her family.

Guiding principle: Citizens will be healthier if their priorities are heard, understood and acted on.

Margaret

Margaret is afraid about returning home and her ability to cope.

Guiding Principle: Citizens will be healthier with smooth transitions between providers.

Let's get there together…

- Participating in the Community of Practice for **System Navigation** (led by Brent Browett, Public Health)

- Exploring ways for hospitals and primary care to be more involved with **housing and income security**

- Leveraging community strategies when possible
  - Neighbourhood Action Strategy (Paul Johnson)
  - Hamilton's Plan for an Age-Friendly City

Let's get there together…

- We have a group of stakeholders **from multiple organizations across the city** working together to improve the coordination of care and services

- These groups have formed around two distinct populations with the greatest identified needs:

Frail, Palliative or Older Adults

Addictions and Chronic Medical Illness
(often with co-occurring mental health concerns

Let's get there together….

- Person-centred **coordinated care planning**
  - Person takes ownership of a document that outlines their action plans, care needs and coping strategies. This is **shared across providers.**

- Plan will help health providers and social service providers to **collaborate with the citizen**

- Ensuring people with complex problems have access to the many family doctors in Hamilton

In closing…

What matters to you?

What matters to our citizens?

How can we continue to work together to create

- *A Prosperous and Healthy Community?*
- *Valued and Sustainable Services?*
- *Leadership and Governance?*