FLAOHT

Frontenac Lennox & Addington
Ontario Health Team

Health Home update

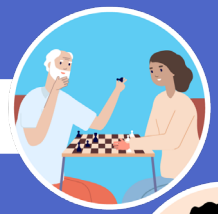
October 2021

Our Health Home and Neighbourhoods Concept

People-Centred Health Home

Public Health Unit

Long Term Care



Home & Community Care Service

Medical Specialists

Pharmacy & Supply Services

Other Health Care Providers

Traditional Healers

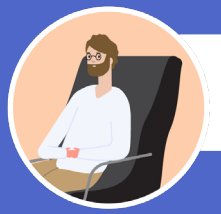
Social Supports

Community Supports

Acute Hospital Care

Sub Acute / Specialty Hospital

Lab & Diagnostic Services



Addiction & Mental Health Services

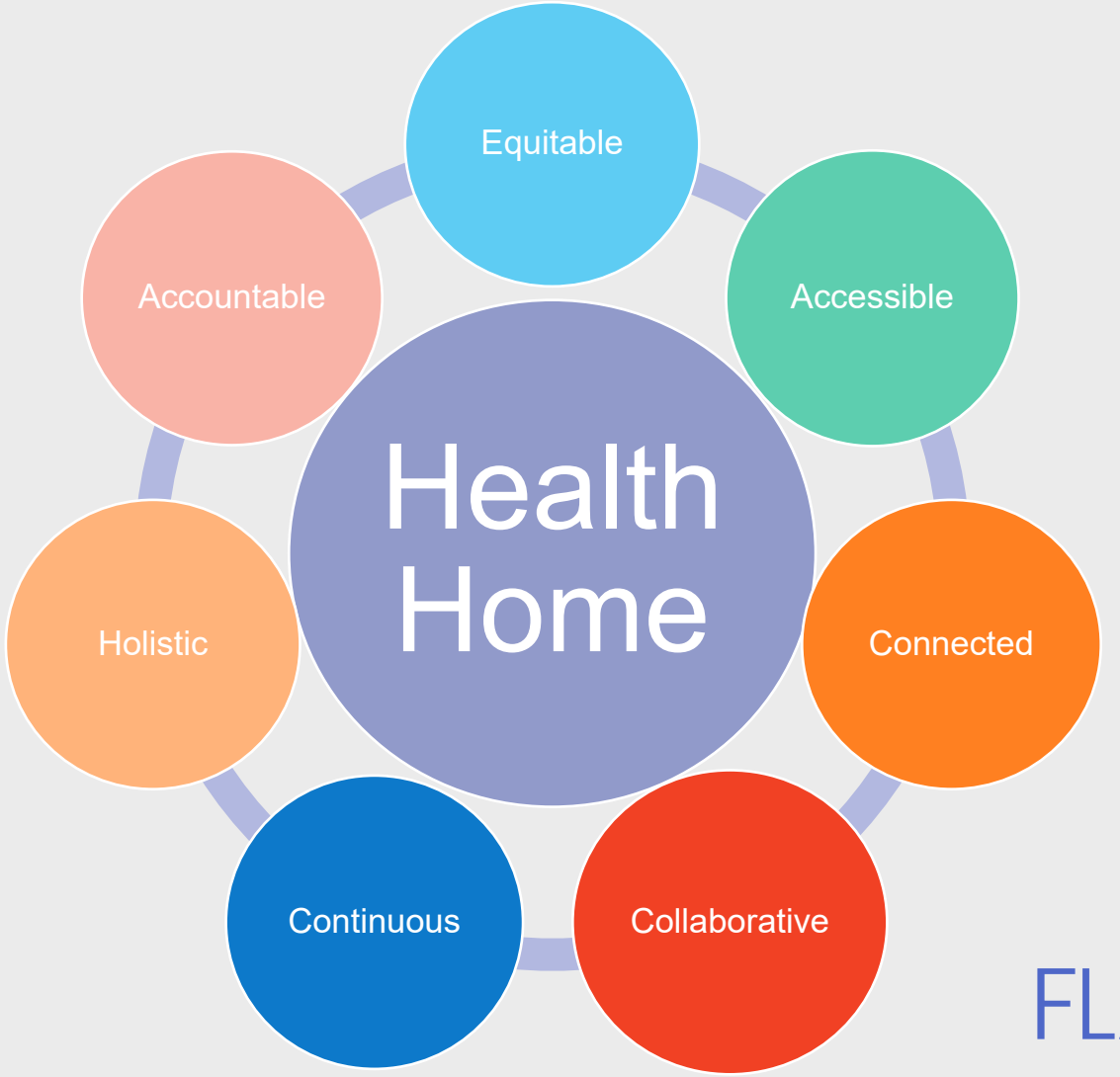
Working Definition

The Person-Centred Health Home is the **first point of contact within the health-care system** that provides people with safe, continuous, person-centered, comprehensive health and wellness services.

It includes fast, easy access, seamless service coordination and navigation support to **keep people safe and healthy in their homes and communities.**

Health Home Principles

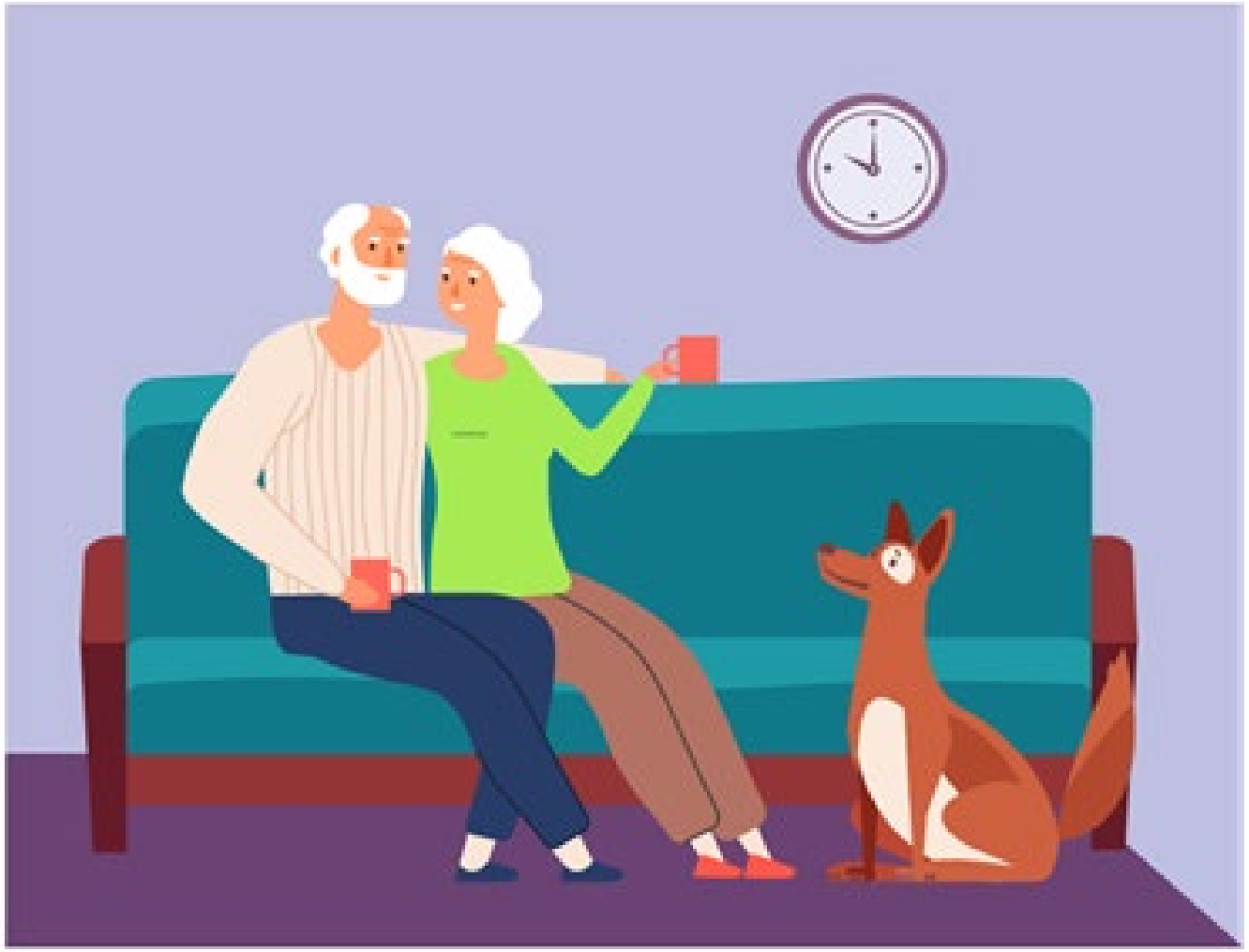
All 7 principles are essential in achieving our over-all vision of the Health Home



Equitable Care

- Everyone in our region is part of a Health Home
- Equitable access to care for those who face obstacles receiving care
- Support everyone in our community to achieve their health goals

Accessible Care



- Access to a Health Home
- Elimination of barriers
- Equitable, respectful, culturally appropriate care and services of individuals, including those who identify as Indigenous and Francophone

Connected Care

- Connected to a robust ‘neighbourhood’ of services
- Leverage digital tools to share health information
- Provide seamless access to health information and services

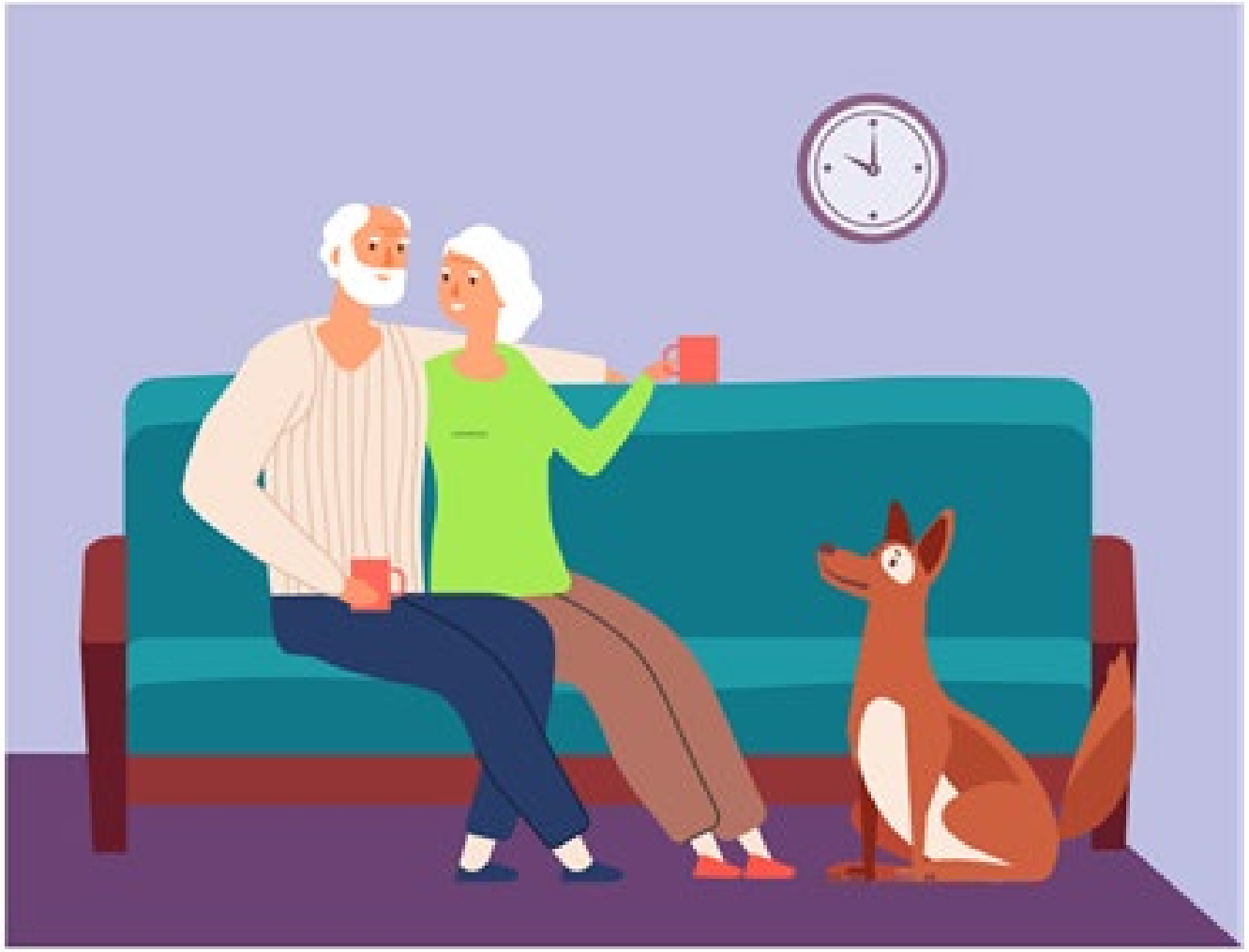
Collaborative Care

- Strong relationships and partnerships to Health Home and other health and wellness providers
- Seek out new partnerships to meet the needs of the persons served

Holistic Care

- Takes a ‘whole person’ approach
- Understands health needs of individuals are unique and multifaceted
- Incorporation of traditional Indigenous healing practices

Continuity of Care

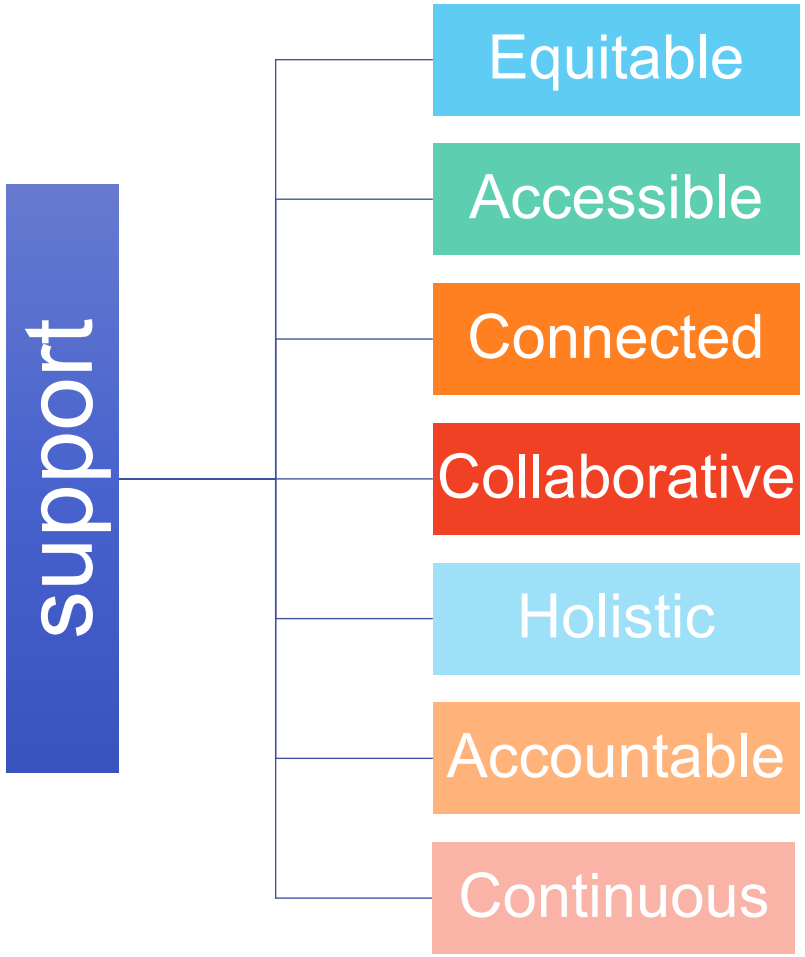


- Delivery of health care over the lifespan
- Foster long-term relationships on the care team

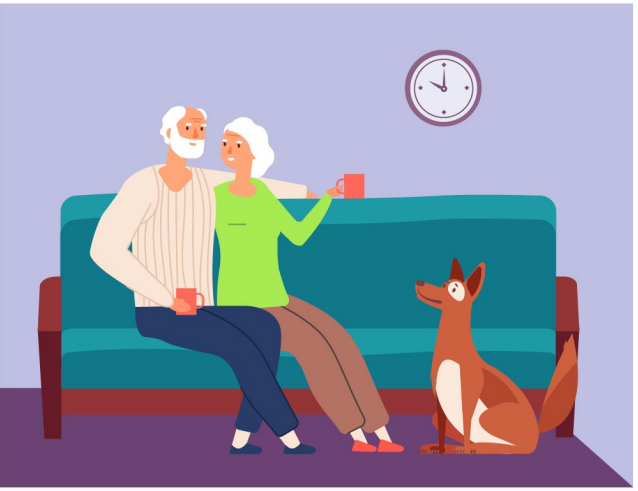
Accountable Care

- Ensure delivery of timely, high quality care
- Monitoring and implementation of best practice
- Attention to privacy and confidentiality
- Leverage tools to collect and share patient information

Health Home Principles



Year-one projects



1. Aging Well at Home

- Aging in place strategies
- Coordinated teams – including home care
- Support for self management
- Identification of “at risk” for hospitalization/LTC decreased ALC

2. Palliative Care Partnership

- Equitable access
- Integrated teams
- Focused on supportive care

3. Integrated Addictions & Mental Health Support

- Hub and spoke model based in primary care
- Improved access
- Collaboration of current agencies

4. Coordinated Discharge

- Coordinated teams – no gaps in transitions
- Fewer readmissions/ ER/ALC
- Supported by digital strategy
- Attachment to health homes for all discharges

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Thank you for being a part of our Team!

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