



LEARNING TO LIVE WELL

Serving Clients At The Penticton Integrated Health Clinic

Creating an Integrated Health Clinic in Penticton may have looked like a simple process – pull together the services that support individuals living with heart, kidney or diabetes conditions under one roof, and provide a coordinated approach to meeting their health care needs. After all, who cannot see the benefits in creating one centre rather than many, in eliminating costly duplication, in reducing hospital visits, and in providing better service to community members? In the end, it took many committed partner organizations, grassroots community support, several planning exercises, three years... and a lot of patience, before the doors of the stand-alone clinic finally opened in 2005.

Those doors are now open six days a week plus some evenings. With a referral from a family doctor or another health care provider, a client receives a call from the clinic, which leads to a full individual assessment. They are then coached in creating a personal plan for improved health and have access to a range of professional care providers, a menu of classes to choose from, and ongoing follow up and support for as long as needed.

Penticton resident David Kroshinsky was referred by a kidney specialist to the Integrated Health Clinic in the spring of 2005. "Everyone was eager to help – I got support from five specialized people in a single visit. The clinic also has a very relaxed feeling – it feels different than going to a hospital."

The support David received was not limited to addressing his kidney health concerns. A number of staff worked with him after an initial assessment. "In addition to seeing the renal nurse, I had my medications reviewed, and I saw a dietician who reviewed my eating habits and showed me things I could do to support a heart and kidney healthy diet. Someone also checked out my activity level – I'm a runner, so they found I was already doing more than expected."

Those registered at the clinic are referred to as "clients" (rather than patients) and there is a strong commitment to a self-management approach - meaning clients are responsible for their own health and the clinic is there to assist them to do just that. According to Bev Arsenault, Clinic Manager, "We used to say, 'I need to see you again in three months and here's what we need you to do.' Now we say, 'I'm here to help you plan for your health, to teach you the skills you might need, and to support you in achieving your goals.' It seems an obvious idea, but it isn't the way patients and health care providers have always understood it."

Every client is initially directed to two classes, called Getting Started. These two and a half hour sessions support them in everything from how to work with the clinic itself to discussions on the specific chronic conditions they are living with. They also learn about healthy eating and active living, topics that are useful to all. As they begin to schedule their visits to the clinic, they discover they have access to a great deal of support.

Clients may need very specific assistance. For example, people with combined diabetes and heart conditions may need to learn about starting or managing insulin and about blood pressure control. They might also choose to attend disease-specific classes on Living Well with Diabetes or Cardiac Basics. In a more generic vein, they could join a class on healthy eating, obtain a referral to the Active Living Centre (an exercise program, in partnership with Pasadena Fitness), choose to attend a smoking cessation program or to learn relaxation techniques.

Bev Arsenault explains it this way, “The beauty of an interdisciplinary approach is that a client with multiple conditions can find the support that’s needed in one location and in a coordinated way. This was all fragmented in the past – now we’re seeing clients served more quickly, more efficiently and with many more services available.” She noted that this would never have succeeded without strong partnerships – starting with the diabetes, heart and renal programs working together.

The journey down the path to integration began with an endorsement from Interior Health Authority management, as well as seed funding from the Healthy Heart Society (which also funds the hearts@work screening and education program, coordinated through the clinic). Other partners included the City of Penticton, the Recreation Centre, the Active Living Centre and local family physicians and specialists. The Provincial Renal Agency, Canadian Congestive Heart Failure Network, Canadian Diabetes Association and the Heart and Stroke Foundation are also associated with this innovative project.

Physician leaders have helped champion the clinic and the family physician continues to be the coordinating point for each patient’s health care. “We always keep family doctors in the loop,” says Bev. “Every interaction with a patient at the clinic is recorded and the respective doctor immediately gets a report... with an invitation to call if they would like to discuss it.”

Bringing three different groups of services together under one roof, and shifting to a self-management approach at the same time, has not been without challenges for staff at the clinic. Nancy Laramie sits at the front desk and has a broad perspective on clinic operations. “It’s easy to see why this is so much better for clients,” she notes. “If they have renal and diabetes needs, for example, they can come to one clinic and plan a single schedule for everything they want help with. However, it’s been a lot of hard work for staff to pull three programs into one.”

That hard work includes creating a single record-keeping and scheduling system. It also includes cross-training the staff nurses and dieticians to provide a more flexible and seamless service for the clients. “Shifting to a self-management approach takes time and practice too,” says Bev Arsenault. “It’s so gratifying to see professionals mentoring each other. For example, the heart health nurse now has the capacity to see straightforward diabetes patients and vice versa.”

Other care providers are keen to work with the clinic as well. Staff recently worked with Mental Health case managers to provide health screening for more than 100 of their clients. The screening helped identify client risks for chronic illness. Workers were then able to offer support around important healthy living issues, such as smoking cessation, access to fitness programs and information on nutrition. This partnership will be ongoing.

After years of planning, and overcoming many hurdles, the Penticton Integrated Health Clinic is open and achieving positive results. The last word, appropriately, comes from client David Kroshinsky, “I like the coordinated approach – they each have a piece of expertise, it’s all tied together in a complete and thorough way... and it works.”