HealthLinks / Maillons santé

Coordinated Care for People Living with Complex Needs

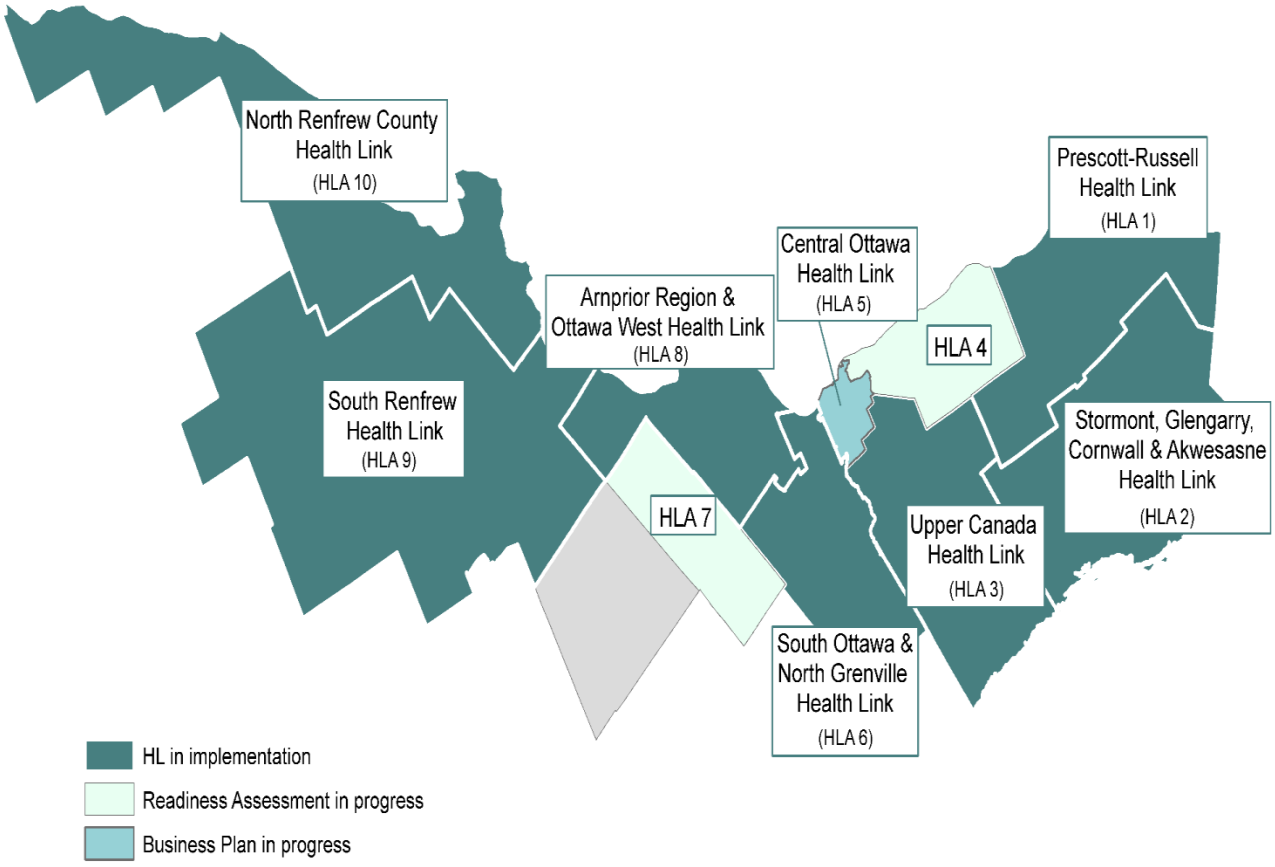
Joanne Sidorchuk *BScPT, MBA, CPA-CMA*
Stormont, Glengarry, Cornwall & Akwesasne
Health Link Manager

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

What Is Health Links?

- A new **model of care** for High Cost-Complex patients
- Health Links is about communication & collaboration
- Health Links is funded by the MOHLTC
- Each Health Link has a lead agency

Champlain Health Links (December 2015)

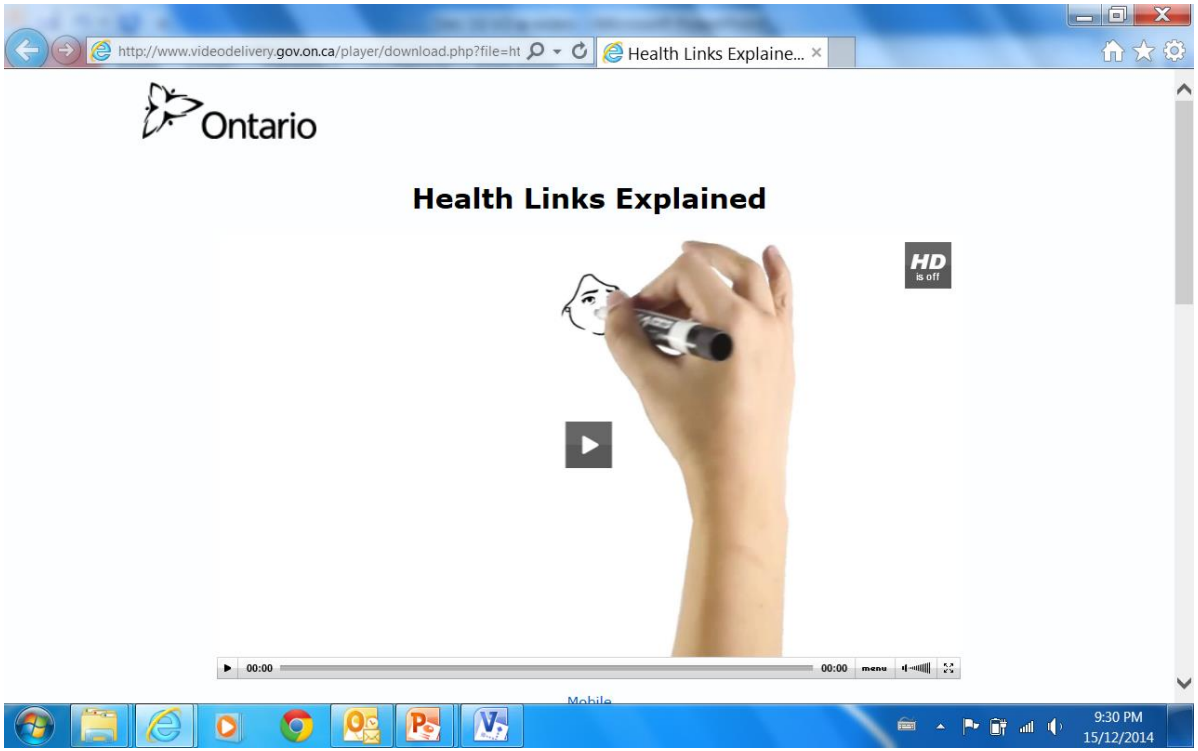


Map and data support provided by the Champlain LHIN.

Health Links Explained

Click on the link below.

https://www.youtube.com/watch?v=gYT7P5Or1as



Health Link Care Coordinators are like the helpful daughter/son you wish every patient had.

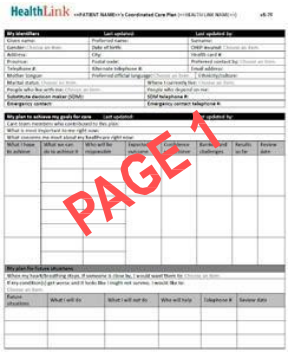
What Health Links is NOT

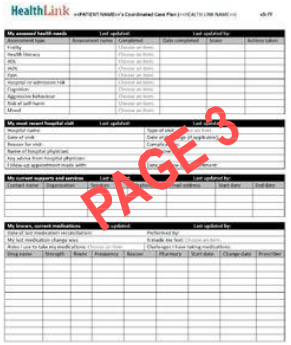
- Rapid response or 24/7
- A replacement for any other service
- A social work service
- A program, department, service

Health Links are here to stay.

The Provincial Coordinated Care Plan

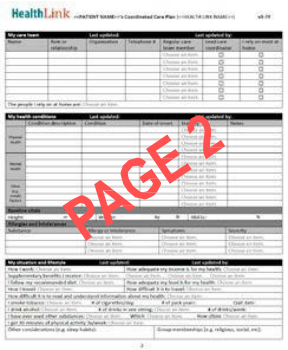
- Identifiers
- Patient goals and care plan
- Advanced care planning information

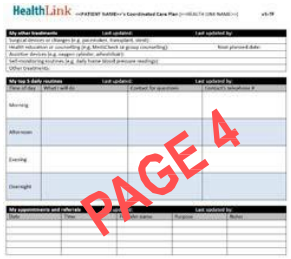




- Assessments
- Recent hospital visit
- Social supports
- Medications

- Care team members
- Health conditions and issues
- Social history





- Other treatments
- Key daily routines
- Upcoming appointments

The Story of Jack

- 68 year old, estranged from family
- Lives alone in a filthy upstairs apartment, no elevator
- 2012 - Broken ankle d/t a bicycle accident – casted
- 27 ED visits over next 3 years with anxiety, depression, drug overdose, suicidal ideation. C/o ankle pain each time.
- Dx- non-union fracture of ankle, 6 mths later pinned
- Developed osteomyelitis
- BKA summer 2015
- Left AMA, returned next day with broken hip
- In 12 months 7 admissions, total LOS = 199 days
- Non-cooperative
- Unable to return to his apartment, finally agreed to temporarily go to group home…an hour away.

What Did the Health Link Care Coordinator Do?

- Created a trusting relationship, used motivational interviewing, 8 visits, weekly phone calls
- Completed Health Link Provincial Coordinated Care Plan & shared with pt and team (OT/PT/CMHA/PCP/Group Home Owners) – including pt goals
- Communication between the team
- Facilitated birth certificate & OHIP application
- Ensured had drive to appointments
- Connected with PCP – sent pt info ahead of time
- Went with pt to Physiatrist appointment

How is Jack Now?

- Keeps his room clean, is well groomed
- Down to 6 cigarettes per day and working with PCP to wean off opioids
- Attending anger solutions group
- No hospital visits
- Has his own walker
- Getting prosthetic limb next month
- Improved outlook on life