

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

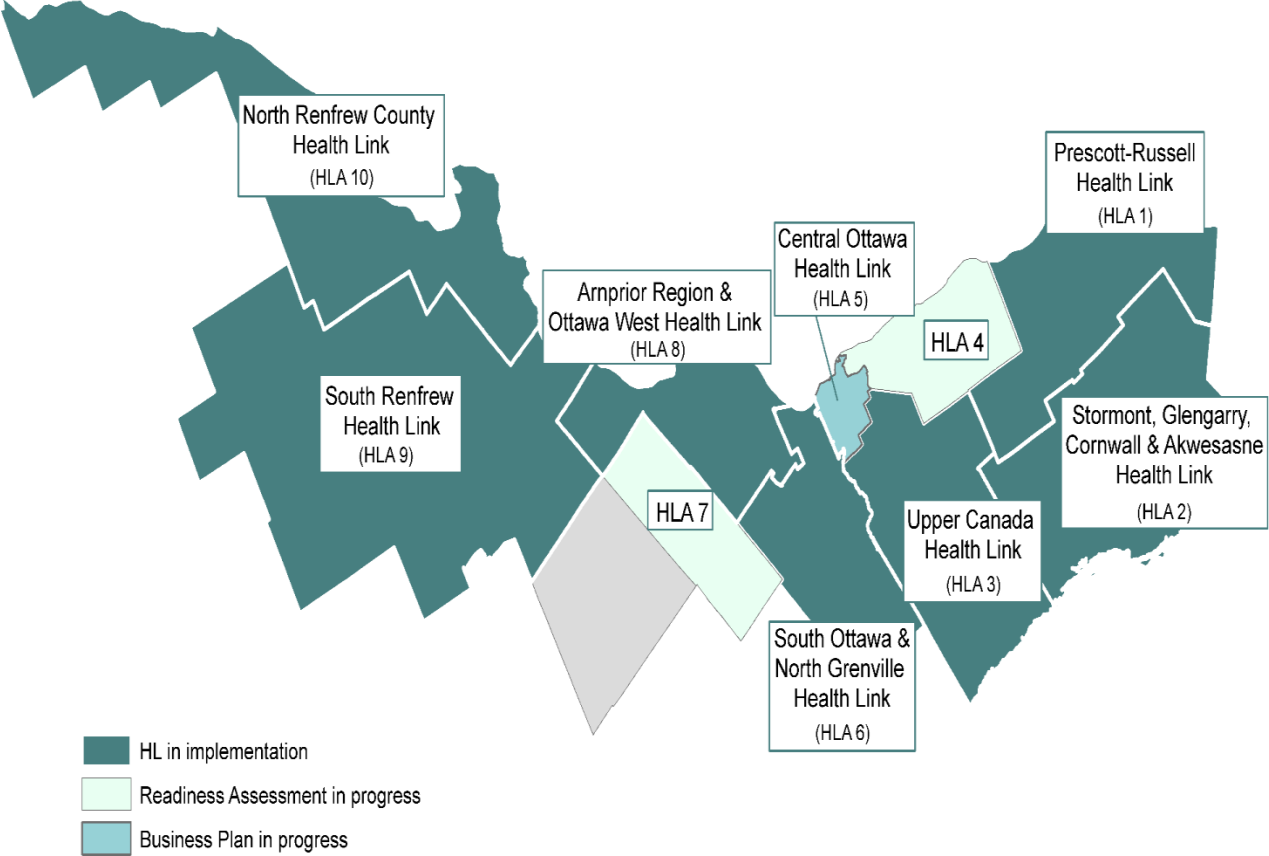
Local Health Integration
Network

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)

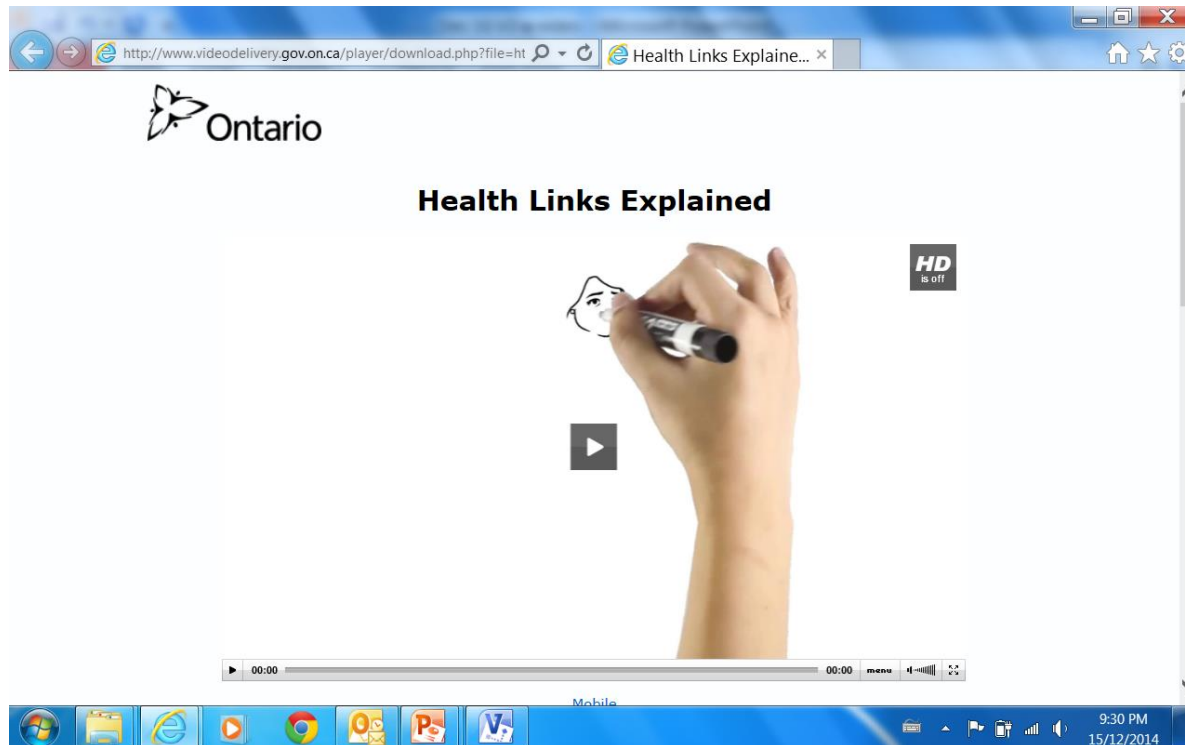


Map and data support provided by the Champlain LHIN.

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

HealthLink - PATIENT NAME'S Coordinated Care Plan (HEALTH LINK NAME) v4.00

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My identifiers	Last updated	Last updated by
Client ID	12/15/2014	12/15/2014
Family	12/15/2014	12/15/2014
Address	12/15/2014	12/15/2014
Phone	12/15/2014	12/15/2014
Insurance	12/15/2014	12/15/2014
Emergency contact	12/15/2014	12/15/2014

HealthLink - PATIENT NAME'S Coordinated Care Plan (HEALTH LINK NAME) v4.00

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My assessment/health needs	Last updated	Last updated by
Family	12/15/2014	12/15/2014
Health	12/15/2014	12/15/2014
Psych	12/15/2014	12/15/2014
Social	12/15/2014	12/15/2014
Functional	12/15/2014	12/15/2014
Quality of life	12/15/2014	12/15/2014
Advance care planning	12/15/2014	12/15/2014
Other	12/15/2014	12/15/2014

- Assessments
- Recent hospital visit
- Social supports
- Medications

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

HealthLink - PATIENT NAME'S Coordinated Care Plan (HEALTH LINK NAME) v4.00

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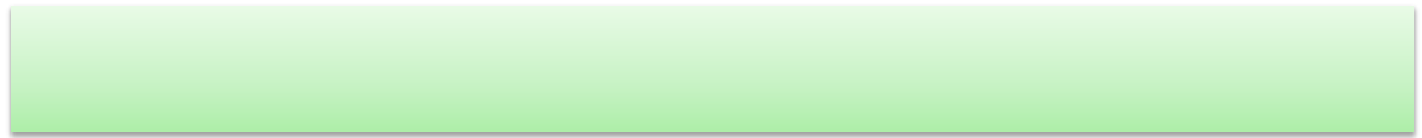
My care team	Last updated	Last updated by
Physician	12/15/2014	12/15/2014
Nurse	12/15/2014	12/15/2014
Pharmacist	12/15/2014	12/15/2014
Other	12/15/2014	12/15/2014

HealthLink - PATIENT NAME'S Coordinated Care Plan (HEALTH LINK NAME) v4.00

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My other activities	Last updated	Last updated by
Health	12/15/2014	12/15/2014
Psych	12/15/2014	12/15/2014
Social	12/15/2014	12/15/2014
Functional	12/15/2014	12/15/2014
Quality of life	12/15/2014	12/15/2014
Advance care planning	12/15/2014	12/15/2014
Other	12/15/2014	12/15/2014

- 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 Psychiatrist 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

