HealthLinks
North Renfrew County

North Renfrew County Health Link Communiqué

Fiscal Year Update

The fiscal year of North Renfrew County Health Link is coming to a close. With that is the opportunity to look back on the first year of the implementation of North Renfrew County Health Link. We acknowledge the great support of our community partners. You have provided us with guidance and oversight through our Steering Committee, our Care Coordination Working Group and our various board and team presentations.

We especially want to acknowledge Renfrew County Paramedics, Champlain CCAC and Renfrew County Community Mental Health for providing staff members to be trained as Health Link Care Coordinators. And to our clinical partners who have trusted us to refer some of their most complex patients and clients, thank you as well.

We have exceeded our Year 1 target of initiating thirty Coordinated Care Plans (CCPs). Currently, we have 34 active patients, with 9 transitioned. In Year 2, the LHIN target for NRCHL is 120 initiated Coordinated Care Plans. This target is cumulative, so it will include our final Year 1 numbers.

North Renfrew County Health Link Accountability Framework

The challenge of Health Links is to coordinate care for the most complex patients within existing resources. With that in mind, our Steering Committee has adopted a sustainable framework which we think will meet this goal. (See figure 1 on page 2).

Virtual Team: Care Coordinators within individual organizations use the CCP template as a way to plan and deliver care for the patients they identify as Health Link patients. Internal care coordinators conduct this work, using mandatory templates and reporting. They form care teams around their particular patient. They act as the prime care coordinators for their particular patient. However, they have form a virtual interdisciplinary team of care coordinators from a range of different health and social service organizations.

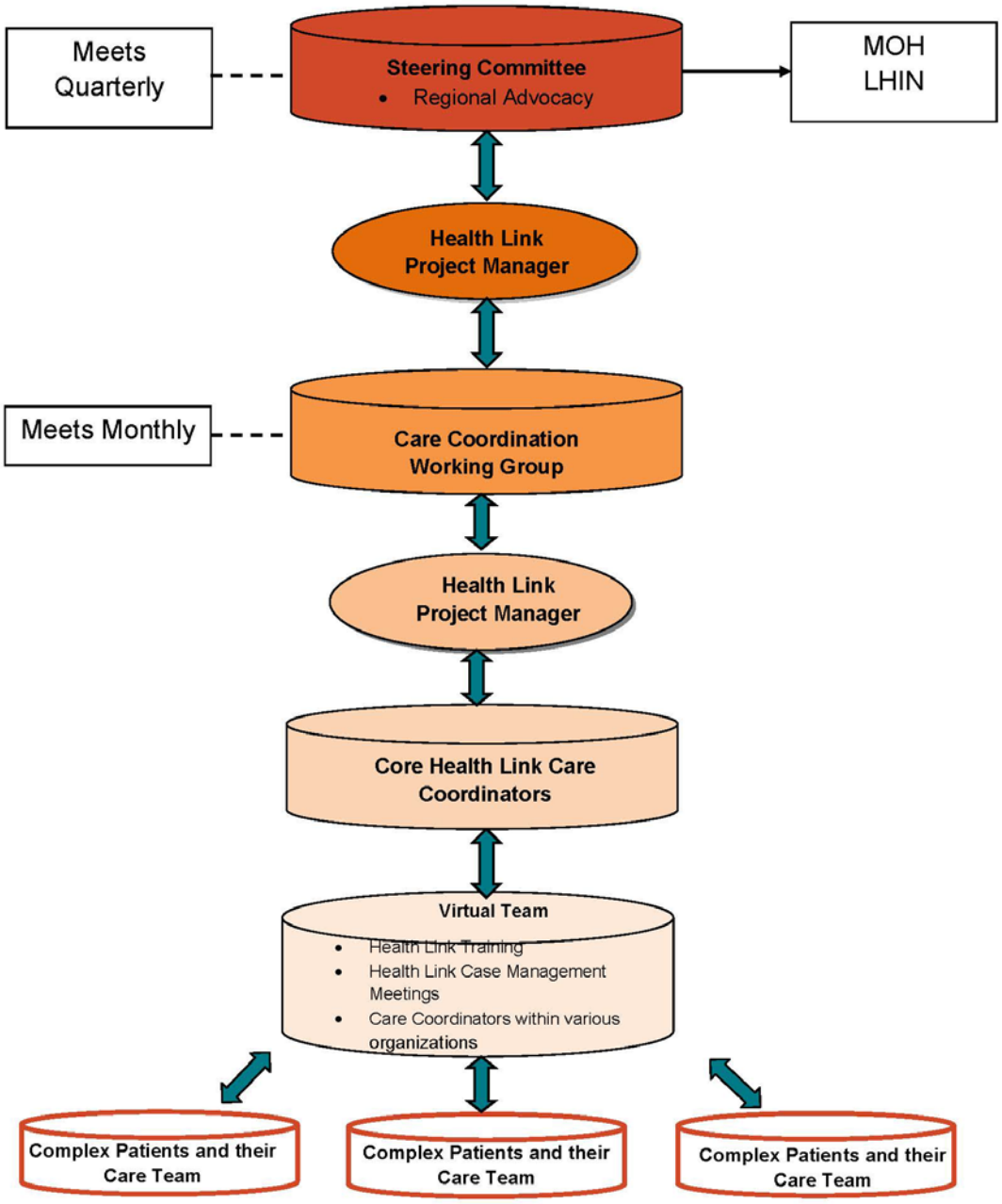
This virtual team uses the same template, uses the same electronic platform, and taps into the team's professional expertise. On a regular basis, the virtual team meets for face-to-face inservices to discuss common themes. This team has access to a smaller core team of Health Link Care Coordinators and the Health Link Project Manager.

Core Team: This core team of Health Link Care Coordinators work outside of their home organization. They handle complex patients who have been identified outside of participating organizations, perhaps through ER usage data or by virtue of being unattached patients. They also serve as patient advocates on behalf of the internal care coordinators, filtering and compiling requests for additional services for Health Links patients. They also work with the Health Link Project Manager to advocate for better local processes and resource allocation. They help with the training of internal care coordinators, and with the continuing education of those internal care coordinators.

Coordination Working Group: This group was formulated in Year 1 of NRCHL. Its mandate includes reviewing all operational details of Health Link care coordination and making recommendations to the Steering Committee.

Care Steering Committee: This group is responsible for the implementation of the Health Links model of care within the NRCHL geography.

Figure 1 NRCHL Accountability Framework



We look forward to adopting this model, learning at each step from our partners.

For more information on this exciting initiative, please contact Jennifer Kennedy, Project Manager:

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