HealthLinks
Western Champlain

Western Champlain Health Link Communiqué

For complex patients, transitions between healthcare settings can be difficult. These transitions may be from the inpatient unit of a hospital back home after an acute illness. Or transitions might be from a large urban hospital for specialty care, to a smaller rural hospital for continued recuperation. The connectivity that Health Links tries to foster is, in part, to improve these transitions. Health care professionals sometimes refer to ideal transitions as “warm hand-offs”, something with more resonance during such a cold January.

Celebration

Western Champlain Health Link is coming up to its first full year in existence. As part of the fiscal year 2018-19, we were given the responsibility of working with complex patients to develop 435 Coordinated Care Plans. These Coordinated Care Plans (CCPs) state the patient’s goals, and bring together a team of providers to support these goals. They are available electronically to members of the patient’s care team. We are please to state that we have hit the mark of 400 CCPs, and we expect to meet our full target of 435 by the deadline of March 31st. In total, there are 568 active Health Links patients in the Western Champlain Health Link. **A big thank you for all the partnering organizations leading the way in providing patient-centred care.**

Patient Story

“Simon”, a 62 year old gentleman, was identified as a Health Link patient in July 2018 by a discharge planner in a small hospital. While in hospital, he was diagnosed with diabetes and educated to administer insulin. His other co-morbidities include Chronic Obstructive Pulmonary Disease (COPD), arthritis, chronic pain, hiatus hernia, gastritis, and Irritable Bowel Syndrome. Simon is scheduled for prostate surgery in February 2019.

Simon has dyslexia and has completed his Grade 12 education. His anxiety about his dyslexia means he can struggle to attend his medical appointments.

“I have trouble talking initially with people. I have difficulty focusing. I have always had someone to help me”, he says. His mother used to fill that role, but now he lives 1,400 kilometers away from family.

Simon’s care team members include Debbie, his friend, the LHIN District Care Coordinator, the nursing clinic, his ODSP case manager, the urologist in the town sixty kilometers away, the endocrinologist and the local Diabetes Educators based out of the local hospital. He is without a family physician, but the endocrinologist is overseeing his medications until he is attached to primary care. Debbie has confirmed that he is registered with Health Care Connect, the provincial funded program tracking physicians taking on new patients.

His care-related challenges include getting a family physician, understanding and acquiring the supplies he needs to properly monitor his diabetes.

At the suggestion of the ODSP caseworker, Debbie was able to contact a local service organization to provide and deliver a fridge for his kitchenette. This will enable him to keep his insulin stored properly.

Simon's goals include renewing his prescription glasses, getting dentures, moving into a bachelor apartment and managing his money better. He would like to eat more nutritional foods so he can be at a healthy weight and manage his diabetes, but both his budget and his cooking facilities are limited. He would like help with housecleaning and laundry as his energy is low and he has chronic pain from his arthritis. Additionally, he would like someone to accompany him to his medical appointments.

He has put in a housing application with Debbie's help and is exploring the possibility of his friend being a co-occupant of a supportive housing unit. He has applied for funding for a diabetes diet and new glasses through ODSP. Dentures are not paid for under that program, so that goal will remain unmet. He is taking on new tasks, including setting up subsidized transportation to take himself to a medical appointment in the next town down the highway.

There are no Community Health Centres or Family Health Teams in the area. Debbie's challenge will be to find a health service provider, like a primary care clinician, who can lead his care team long term. Debbie has involved his friend in some of the care planning, and is hoping that the friend will take the lead role, if no health professional is available.

Simon is resilient and resourceful; however, he requires constant reminders of his appointments and monitoring his sugars. He has seen the value of carrying through with the goals he has set in his Health Link Coordinated Care Plan. For instance, as part of his goal for eating more nutritional food on a limited budget, he has found the locations of the local soup kitchens, and has attended them with his fellow tenants. He and his friend have gone together to the food bank, thereby splitting the cost of the taxi ride. Simon is building a sense of community. With his health improving, he recently got some nice clothes, including a leather jacket, which has helped him feel good about himself.

Planning my care

Regardless of whether you might fit the Health Link patient profile, there are things you can think about when planning your care. Think about your health story. What matters to you now? Who do you rely on now and in the future? What is most important to you in the years ahead? Who should help plan your care? What do you want health care providers to know about yourself as a person? What questions do you want to ask your health care team?

Reach Out to the Western Champlain Health Link Team

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