HealthLinks
North Renfrew County

North Renfrew County Health Link Communiqué

As 2017 gets underway, North Renfrew County Health Link Care Coordinators continue to develop relationships with complex patients, hear their stories, and help oversee the coordination of their health services. With trust and creativity, care coordinators are supporting complex patients to meet their stated goals.

One example of this relationship building involved a patient suffering from cardiac symptoms, anxiety and alcoholism and who had multiple hospital admissions. Due to a move, he had been without a family doctor for three years. His concern about his cardiac issues and their possible impact on his sobriety was causing him increased anxiety and bringing him back to the hospital repeatedly. The Health Link Care Coordinator linked him to a family physician. She tracked down information from his previous physician about a successful medical intervention that had contributed to previous periods of sobriety. She was able to ensure that that information was available for his first physician's appointment, also flagging that his anxiety medications be reviewed. She is helping him to obtain hospital medical records of his recent admissions for his insurance provider. He is appreciative of the Health Link's involvement. He feels that his concerns are being heard and that people were working with him. "My care is being coordinated and I don't feel as if I am fighting against the system", he states.

The role of the care coordinator is based on competencies such as of system navigation and relationship building. Not everyone is suited or interested in the role. But for those who are, the role can be very rewarding. In one case, after building a care team to support a previously homeless patient and provide him with comfort and care for his deteriorating health, Colleen Whittier (CCAC) had this reflection: "for the first time in the patient's adult life he had a place of his own. The care team members would come and visit. In his mind, the care team members weren't there because of work. They were his friends. They would often bring him Tim Horton's coffee. Even if visit was only twenty minutes, it made a difference to him. The last few months of [the patient's] life were some of his best. The care team members can all feel we did our jobs well."

As we train more Health Link Care Coordinators, we see them embrace this larger role. Michelle Cassista, of the Community Paramedics, states that Health Link care coordination is "different from what I am used to. It doesn't have to be just medical solutions to what I see in the patient's home. Health Links care coordination opens up my brain".

The work in the next few months is to continue to train and support Health Link Care Coordinators who are just beginning to use this approach in their own organizations. Internal processes may be needed for organizations to adopt a Health Link approach. We expect announcements from regional partners as they answer the call of the LHIN to fully adopt and scale up a Health Link approach with their most complex patients. In its bid to do the work within existing resources, the LHIN estimates that Health Links will continue to find approximately 50% of the care coordination required to serve complex patients. The NRCHL Steering Committee will begin budget planning with that in mind.

To close this communique, we focus on some thoughts from Kate Mooney, Health Link Care Coordinator with Community Mental Health, addressed to front line service providers.

Go beyond your norm

Whatever your typical role (nurse, social worker, PSW, SSW, addiction worker, case worker etc.), as the Health Link Care Coordinator, you become emboldened to have conversations in all these areas. You do not need to be a specialist in any area. However, once a patient's priorities have been identified and recognized as significant, you follow those priorities. Always know that the lead is YOU – until it's not you because you have clearly communicated and another person has taken on the role.

Go beyond the assumption

In healthcare, we tend to make a lot of assumptions. We assume that the referral was made, that the referral arrived, the call was made, the message or fax received, that the patient completed the intake, etc. We also make assumptions about what other agencies can or can not do; should or should not provide. We assume that our clients have phones and that if they do not call us that they are "OK" or not interested in services. We make A LOT of assumptions.

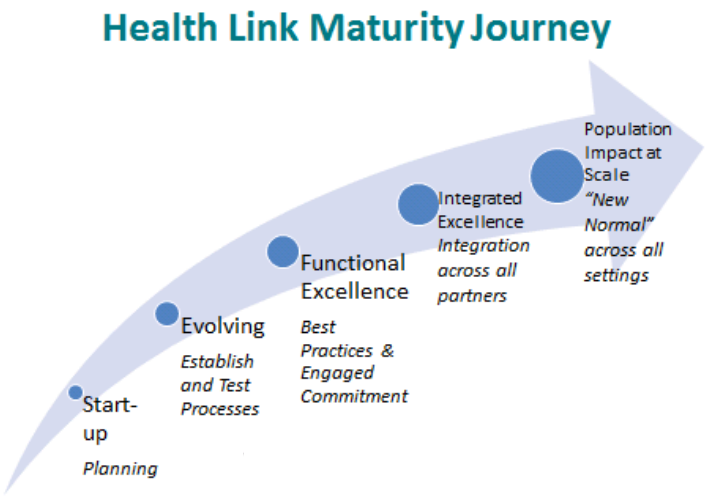
With the Health Link patient, it is a critical realization that we must not make assumptions. Care Coordinators must follow up to ensure that all steps are being completed and directed appropriately. We need to be accountable and hold our peers accountable. This requires a balance of delicate social skills and diligent tracking of details.

Go beyond the average

If the typical level of service were suitable to meet this patient's needs, you would not have enrolled them as a Health Link patient. The Health Link patient may require that you hold inclusive care conferences, create protocols, outline goals and priorities, place documents on the patient's medical records, etc. The patient's needs predict where you will put your efforts.

Go beyond your agency

By building relationships with staff from other organizations, you and your patient will benefit tremendously. You will gain a deeper understanding of the inner workings of your community partners and what can or can not be reasonably accomplished. You can call on one another to problem solve, share information, and to seek additional allies with different areas of expertise. Creating your own community of practice by developing strong professional relationships is a key element of Care Coordination.



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