HealthLinks
Central East
Let's Make Healthy Change Happen

Central East CCAC Community Care Access Centre
CASC Centre d'accès aux soins communautaires du Centre-Est

Health Links Coordinated Care Plan enables Don to live at home

Wanda Power, Senior Manager of Palliative Care with Central East CCAC, meets with Care Coordinators on her team who apply coordinated care planning practices for patients.
Left to right: Nicole Hughes, Wanda Power, Stacey Gamble, and Kimberly Stone.

Don's wish to continue living at home is being achieved with the support of a Health Links Coordinated Care Plan (CCP).

Don*, who is a long-stay patient of the Central East CCAC, receives personal support services to help manage his multiple sclerosis condition. He is also supported by his family and a private personal attendant. Recently, Don's family noted a decrease in his physical abilities and that he might be getting injured during two-person transfers in moving from his bed to a chair. They were also concerned about personal support scheduling issues.

Responding to the family's concerns, the Central East CCAC initiated a **Health Links Coordinated Care Plan** process with everyone involved in Don's care.

Meeting in his home, Don, his wife, daughter and son-in-law attended a **Coordinated Care Conference** along with the Central East CCAC care coordinator, the personal support worker, and the private personal. During the meeting, Don clearly expressed his goal to live healthier and happier at home to his Care Team. This included getting up to eat dinner with his family and being mobile in order to have at least two showers each week. He also wanted to improve communication and consistency with his service providers.

The **Health Links Coordinated Care Plan** initiated by Don's Care Team supported his goals and, following the **Coordinated Care Conference**, changes were made to his care including the provision of in-home occupational therapy to assist personal support workers and attendants with safe transfer techniques and in-home physiotherapy to help increase Don's range of motion. A new schedule for personal support workers reflected Don's eating and showering goals and all providers shared contact information and schedules to ensure consistency of service. The Central East CCAC also conducted an in-home re-assessment to ensure Don's care needs were being met.

"*This is a true success story of the value of the Coordinated Care Plan and Coordinated Care Conference. By gathering all of the patient's care providers and his support system together to acknowledge what is most important to the patient, key members of the circle of care were able to hear the patient's story and goals*," said Wanda Power, Senior Manager of Palliative Care, Central East CCAC. "*Together we were able to talk about what works well, what is not working well and come up with a plan together. There was collaboration and team building during the care conference between the patient, his family and all providers of care. This holistic approach supports everyone. It takes a village to raise a child and a village to care for an individual with as many physical challenges as Don, and together we are achieving that as a team*."

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Quick Facts

- The **Central East CCAC** provides home and community care services to more than 38,600 patients each day.
- A **Health Link** is a local health care network consisting of patients, caregivers, health care providers and community support agencies who are committed to working better together to improve the health outcomes for patients with complex health care needs.
- Through enhanced collaboration among Health Link network organizations, patients with complex health care needs, along with their health care providers, will develop individual **Coordinated Care Plans (CCP)** that more effectively meet their goals and ensure smoother transitions between care providers.
- **Health Links** are perfectly positioned to implement the action steps and directions in the **Patients First** plan.

** Names changed to protect privacy*

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