A coordinated and integrated care approach supports patients in their journey

Back row: Jeannie Huan (The Scarborough Hospital- Gen Home First ECC), Kiran Scott (CIA Coordinator), Angela Pagniello (Rouge Valley Health System – Centenary Home First ECC), Shawn Cadieux (CIA Coordinator)
Front row: Kerri Gogar (The Scarborough Hospital – Birchmount Home First ECC), Misha Heravi (CIA & Home First ECC)

Sue* has a complex health care history that includes diabetes, hypertension, asthma, arthritis, breast and lung cancer and gets around in a wheelchair after a stroke left her with weakness on her left-side. With the support of her family doctor, services provided by the Central East Community Care Access Centre (Central East CCAC) and a live-in family member who managed her medications, appointments and daily care needs, she had been living in her own home in Scarborough.

But when her live-in family member passed away suddenly, Sue felt overwhelmed and headed to the emergency department at The Scarborough Hospital – Birchmount Campus where she was admitted.

Because she was an active Central East CCAC patient, a *Home First* alert was triggered when Sue was admitted to the hospital and the Central East CCAC Care Coordinator, TransCare Community Support Services (TCCSS) *Home First* Enhanced Care Coordinator (ECC), and TCCSS Client Intervention and Assistance Coordinator (CIA) visited her at the bedside.

An active partner with the Scarborough North and Scarborough South Health Links, TCCSS provides home and community support services for people who need assistance due to illness, convalescence, disability or functional limitations related to aging. While in hospital, TransCare, hospital staff, and Central East CCAC partnered with Sue to initiate a Health Links Coordinated Care Plan (CCP) and establish a Care Team to support her in the community.

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After confirming that acute care was no longer required, the Care Team's goal was to ensure that Sue had the support she needed to be discharged home.

Working together, the *Health Links* Care Team supported her transition home by providing:

- A Personal Support Worker from TransCare's *Home-at-Last* service who accompanied Sue when she was transported home;
- Meals through TransCare's Meals-on-Wheels service;
- Central East CCAC Personal Support; and,
- Joint visits to Sue's home by TransCare and Central East CCAC to check on her safety and well-being as work continued on the long-term care home application.

Sue's care was successfully managed in the community until she was offered a Long-Term Care bed. She is now thriving in her new home where she has all her care needs met.

The initiation of the Coordinated Care Plan (CCP) allowed Sue to be proactive in voicing her needs and wants and, in providing her consent to have the CCP shared with other members of her Care Team, ensured that all Care Team members were able to work collaboratively to support her journey from home to hospital to home.

"*The CCP process begins with having a solid team who can identify patients who can benefit from the CCP and to be able to carry the process through. Like all of the health care partners in the Central East LHIN, our co-ordinators are well-known for their collaborative work with all of our hospital and community partners and this benefits our clients directly. The CCP is not only a document – it's a valuable and meaningful interaction in involving our patients in their own care*."

- Gurprit Matharu, Director, Integrated Care, TransCare Community Support Services

Quick Facts

- 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.
- Local Health Link networks are perfectly positioned to implement the action steps and directions articulated in the ***Patients First*** action plan at the sub-regional level and achieve the **Central East LHIN Strategic Aims**.
- The **Central East LHIN** mission is to lead the advancement of an integrated sustainable health care system that ensures better health, better care and better value.
- **Home First**, a Central East LHIN Initiative, is a collaborative approach between hospitals, the CCAC and community agencies to improve hospital bed utilization, and facilitates the timely and safe return home of every individual who enters the hospital.

For more Information on Health Links please visit
http://www.centraleastlhin.on.ca/goalsandachievements/healthlinks.aspx

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** Names have been changed to protect patient privacy.*