

Care Coordination: A Case Study Linking Primary Health Care

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The purpose of this project is to demonstrate, through a case study, how York Community Services (YCS) is a leader in the delivery of primary health care through its integration of health, legal and social services. YCS is located in Toronto, Ontario, Canada. YCS's mandate is to serve populations that have traditionally been on the margins of society and therefore have had difficulty accessing the health care system. These include victims of domestic violence, the isolated senior, those with severe mental illness and children living in poverty. Care coordination is a unique model developed by YCS whose main goal is to provide a forum for the client's providers to meet, discuss and coordinate relevant information. Care coordination is used to maintain continuity of care among providers.

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According to the World Health Organization, primary care "is the first level of contact of individuals, and family and community, with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing care process" (World Health Organization, 1978).

York Community Services is a community health centre (CHC). Its main role is to provide health, social, and legal services for clients with multiple needs. There are 56 CHCs in Ontario. CHCs are managed by non-profit community Boards of Directors. These Boards are made up of local residents who work or live in the local community. The members of the Board of Directors are the trustees of the organisation and are responsible to meet Ministry of Health guidelines in its operational functions.

YCS employs a full range of staff (37) including physicians, nurse practitioners, nurses, mental health nurses, chiropodists, health outreach workers for the Somalian, Spanish and Vietnamese populations, and social workers. For the many complex clients seen at YCS, case management or care coordination is utilised. Care coordination can be defined as a continuity of health care by linking clients to the service delivery system, planning and monitoring services, which are the main functions of traditional case management (Anthony, Cohen, Farkas, & Cohen, 1988; Curtis, Millman, Struening, & D'Ercole,

1992; Franklin, Solovitz, Mason, Clemons, & Miller, 1987; Goering, Wasylenko, Farkas, Lancee, & Ballantyne, 1988). Case management is a "coordinated strategy on behalf of clients to obtain the services that they need, when they need them and for as long as they need these services" (Solomon, 1992, p.164).

There are a variety of case management models in practice:

1. The Broker Model - the case manager helps the client to negotiate the fragmented system of care available in the community by assisting with referrals and linkage to the community resources (Mental Health Case Management Association of Ontario [MHCMAO] Training Resource Guide, 1993). The underlying belief is that a person's quality of life would improve if linked to necessary services.
2. The Rehabilitation Case Management Model - increases the client's functioning in the chosen environment by building skills and developing environmental supports. The emphasis is on restoring and/or improving function rather than the alleviation of symptoms.
3. The Clinical Case Management Model - helps the client to achieve stability at his or her best level of functioning in the community, and once the client achieves stability, the Clinical Case Manager turns the focus towards facilitating growth at a pace that does not undermine the client's achievement of a stable life (MHCMAO Training Resource Guide, 1993). This model is based on the belief that under optimal conditions all people are capable of positive change.
4. The Strength Model of Practice - assists clients in identifying, securing and sustaining the range of resources both environmental and personal needed to live, play and work in a normally independent way in the community (MHCMAO Training Resource Guide, 1993). It is based on the belief that people are successful when they use and develop their own potential, and when they have access to the resources that they need.

Many of our vulnerable clients have multiple service providers. YCS has adopted a case management model

wherein flexibility is promoted to enhance the care given to the client. Once a lawyer, social worker, nurse, nurse practitioner or physician identifies that a client's needs extend outside of their own area of expertise, they formally refer the client to the most appropriate individual. An Internal Referral Form is filled out and sent to that particular individual or sector according to centre policy. This intake process is triaged and prioritised accordingly.

The client is then contacted, an assessment is made, and a plan of care is implemented. Ongoing assessments and care plans are then discussed at bimonthly Care Coordination Meetings. The meetings are organised as follows:

1. Second Thursday of the month, the health sector meets with the social sector. The social sector includes one-third mental health, one-third older people, and one-third newcomers.
2. Fourth Thursday, the health sector meets with the legal sector, the legal sector meets with the social sector and then all three sectors meet together.

Vital information is shared, communicated and discussed at the Care Coordination Meetings: "Direct [coordinated] support services make a significant difference on reducing annual hospital care" (Kuno, 1999).

In 1989, Mrs. V, an illegal immigrant from Chile, walked up to the main reception desk at YCS seeking "urgent" help regarding a family matter. The receptionist referred her to a social worker trained in the identification of family problems and mental illness.

The social worker assessed Mrs. V., a victim of domestic violence for a decade, as severely depressed. She had two children aged four and six years. Mrs. V. was then referred to the legal and health departments. By the end of the day Mrs. V. received supportive counselling from the social department, legal advice and a physical and mental health assessment by a physician. Mrs. V. was assigned a file number and her name was automatically added to the Care Coordination client list generated by the information system, thus reviewing her file was easily available for Care Coordination Meetings.

We believe that our model of care is unique. YCS offers a seamless transition and coordinated follow up for the client through the health, social and legal systems. The services "under one roof" concept allows staff to easily

meet informally regarding shared clients and formally through the Care Coordination process.

Over the following year Mrs. V. received counselling, health care and legal assistance. Initially, she did not feel able to leave her husband or press legal charges. However, she continued to attend the clinic regularly. A few months later she felt strong enough to get a part time cleaning job and save a little money.

Her caregivers met formally in the care coordination meetings to discuss her care and coordinate her care plan. Care coordination's main goal is to provide a forum for the client's providers to meet, discuss and coordinate relevant information. Care coordination is used to maintain continuity of care among providers.

Five years later, Mrs. V. presented to our Centre in a frantic state with rope burns from a noose that her husband had tied around her neck that day. Her lawyer immediately saw her. At that point, her lawyer helped guide her through her options. In 1994, Mrs. V. pressed charges against her husband. In 1996, Mr V. was convicted of his crimes and deported to Chile.

The following year Mrs. V. and her two children received landed status in Canada. In a landmark decision, our lawyer successfully argued that Mrs. V.'s life would have been in danger if she returned to Chile.

Mrs. V. identified how the continued support of her social worker, sensitivity of her physician and the information provided by her lawyer empowered her to find a resolution for her situation. The formal integration of health, legal and social services facilitated this process.

The formalised integration of services and service providers is the key ingredient when providing comprehensive care to those with multiple needs. The Care Coordination System, as developed at YCS, is seen as a way to assist clients in meeting their ultimate goal of emotional and physical wellbeing. The system allows the team of service providers the opportunity to communicate, exchange ideas and to develop options for the client to consider in their treatment plan. It allows the team to operate at its maximum capacity by preventing breakdowns in communication between service providers and clients.

Today, Ms. V. runs her own thriving cleaning services business.

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