HealthLinks

Frequently Asked Questions: Patients and Families

1. What is the Health Links approach?

The Health Links approach to coordinated care planning is about bringing patients' health care, social service providers and other supports together to better understand their goals and support patients in a more coordinated way.

A Coordinated Care Plan will help patients and their Care Teams better manage the patient's health and well-being, and the Care Team will work with patients and their families to help patients meet their goals.

Coordinated care planning is meant to support a patient's overall wellness. It considers his or her "whole person" needs – mentally, physically, emotionally, and spiritually. Patients are asked to think about cultural or community support people that they would want included on their Care Team to help support this "whole person" approach (e.g. spiritual support, traditional healer, naturopath, neighbour, friends, etc.)

2. What is Coordinated Care Planning?

The Health Links approach to coordinated care planning promotes a shared understanding of what is most important to the patient through the establishment of a Coordinated Care Plan, inclusive of clear roles and responsibilities for each member of the patient's Care Team.

Coordinated care planning (CCP) allows for more coordination and a streamlined approach as people transition from one provider to another, allowing people to live well in their community and reduce avoidable healthcare utilization.

3. What are the benefits of the Health Links approach to care for patients?

Benefits of the Health Links approach to care for patients include: care being focused on the patient's goals, providers having a consistent understanding of their patients' conditions, easier navigation of health care services, patients feeling more supported in their health care journey, having fewer visits to hospitals, and focusing on improved quality of life.

4. Who can initiate Coordinated Care Planning?

Anyone – a provider, friend, caregiver, the patient themselves. The Coordinated Care Planning process can be initiated while the patient is at home (including Long Term Care, Retirement Home, Assisted Living, etc.) or in hospital. The Coordinated Care Plan can help support transitions from home to hospital and from hospital to home.

5. Who should be involved in Coordinated Care Planning?

The patient helps to decide; the Coordinated Care Planning Team (Care Team) is a group of professional and non-professional care providers, including the patient and caregiver, committed to working better together to support the patient in achieving their goals. A Care Team will include any individual, program or organization that the patient consents to contributing to and being involved in their Coordinated Care Plan.

Care team members could include the following:

- Family, caregivers, supports
- Doctor/Nurse Practitioner
- Nurse
- Specialist (e.g. Cardiologist)
- Allied Health Professional (e.g. social worker, dietitian, physiotherapist)
- Community Pharmacist
- Cultural/Community Supports (e.g. Traditional Healer, Translator)
- Someone from local Hospital (e.g. Nurse from emergency room, Navigator)
- Care Coordinator from Community Care Access Centre (CCAC)
- Someone from Mental Health and Addiction Services (e.g. Counsellor)
- Someone from Community Support Services (e.g. Homemaker Coordinator
- Someone from Social Services (e.g. Ontario Works)
- Other Community Partners (e.g. French Mental Health & Addiction System Navigator, Spiritual Support)

6. Who decides if Coordinated Care Planning will proceed?

The patient decides. While anyone from the list above may be asked to participate in the coordinated care planning process for a patient, not all need to be involved for the process to proceed. No single provider, not even the patient's primary care provider, has the authority to prevent coordinated care planning. As long as a couple of providers and the patient feels that the process would be valuable, coordinated care planning should proceed.

If a provider feels that s/he has the authority to prevent the coordinated care planning process, it would be reasonable for the Care Coordinator to explain that there are enough people, including the patient/client, who have deemed the process valuable enough for it to proceed.

A copy of the coordinated care plan should be shared with everyone who has been invited to participate in the coordinated care planning process, as determined with the patient, including: a) those who support the process but can't attend the conference and b) those who don't support the process.

7. How is a patient's information protected?

When the Coordinated Care Planning Team encompasses the patient, family, and providers within the "circle of care", information and discussion occurs as with any other cross-sector collaboration/communication between providers. A patient consent process is leveraged when the care team includes people/organizations that would not be considered within this circle (e.g. Municipal Housing).