HealthLinks

Let’s Make Healthy Change Happen

What is the Health Links Approach?

Health Links will be integrated across sub-regions as a **patient-centered approach to care** that focusses on enhancing and coordinating the care for patients living with multiple chronic conditions and complex needs.

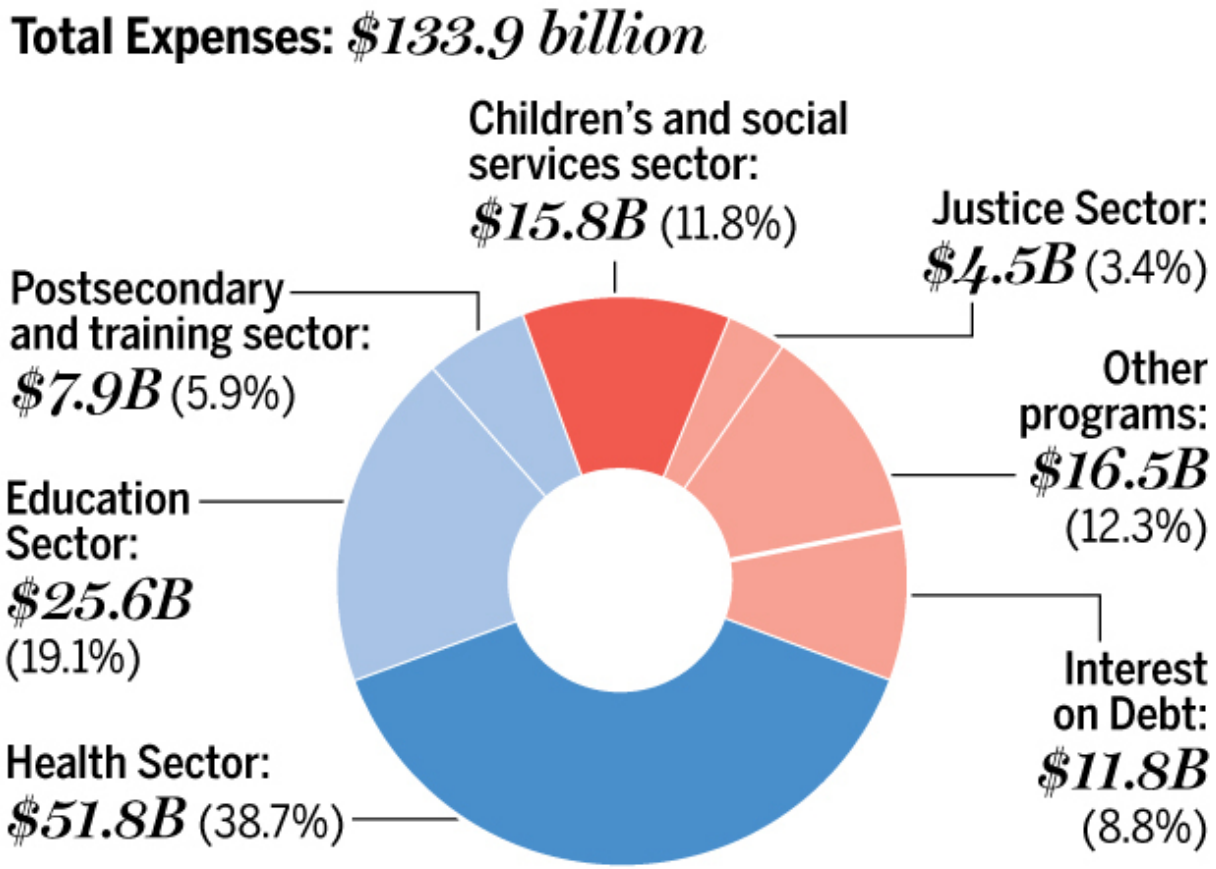
The goal of the Health Links approach to care is to create **seamless care coordination for patients with complex needs**, by ensuring each patient has a Coordinated Care Plan (CCP) and ongoing care coordination.

Who is involved with the Health Links approach?

The Health Links approach is a good example of how Ontario is working to bring together providers and health organizations to work as a team with patients and their families.

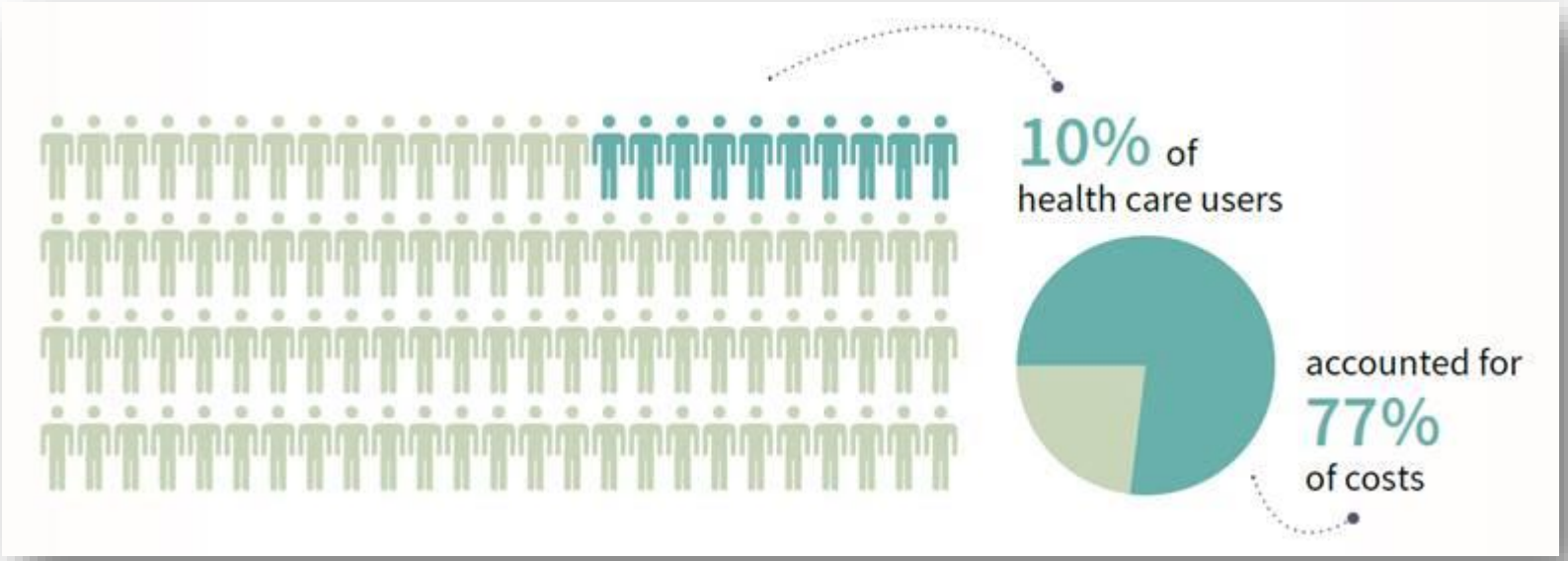
When the family doctor or nurse practitioner, community organizations, specialists, the hospital, the long-term care home and others work as a team, patients with multiple, complex conditions receive better, more coordinated care.

Provincial Expense Distribution



Source: Ontario 2016 Budget

Proportion of Health Care Expenditures in Ontario



Source: Wodchis WP, Austin PC, Henry DA. A 3-year study of high-cost users of health care. CMAJ 2016 Jan. 11

With no changes, the impact of demographics alone would add $24 billion in spending within 20 years, 50% increase, not including inflation.

Target Population

At present, the target population for the Health Links approach to care focuses on people living with 4 or more complex or chronic conditions.

Identified sub-groups include:

- Those with Mental Health and Addictions challenges
- Palliative Population
- People who are frail

Other considerations:

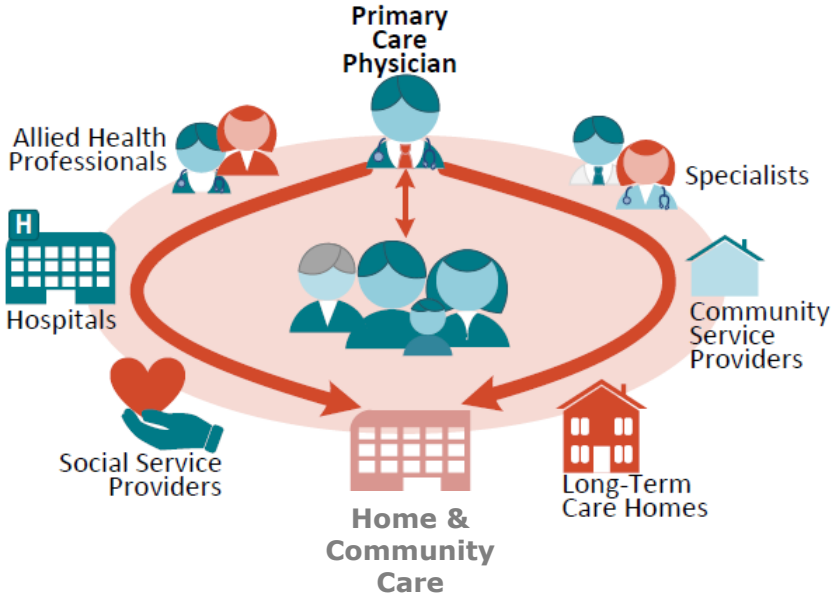
- Economic characteristics (e.g. low income, unemployment)
- Social determinants (e.g. challenges with housing, social isolation, language)
- High users of hospital based services (i.e. Emergency Departments or primary care visits)
- Clinical judgment

Benefits of Health Links and Coordinated Care Planning

- 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
- Patients having fewer visits to hospitals, and focusing on improved quality of life

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

- Most people with **many health care needs** see **a lot of different people** for support
- It **can be hard for patients/clients and their families** to arrange appointments, travel to appointments, and keep all information straight
- It can be **difficult for providers** to understand **how** they each **best support** people with many care needs

INDIVIDUAL AND HOUSING MANAGER

INDIVIDUAL AND PERSONAL SUPPORT WORKER

INDIVIDUAL AND ADULT DAY PROGRAM STAFF

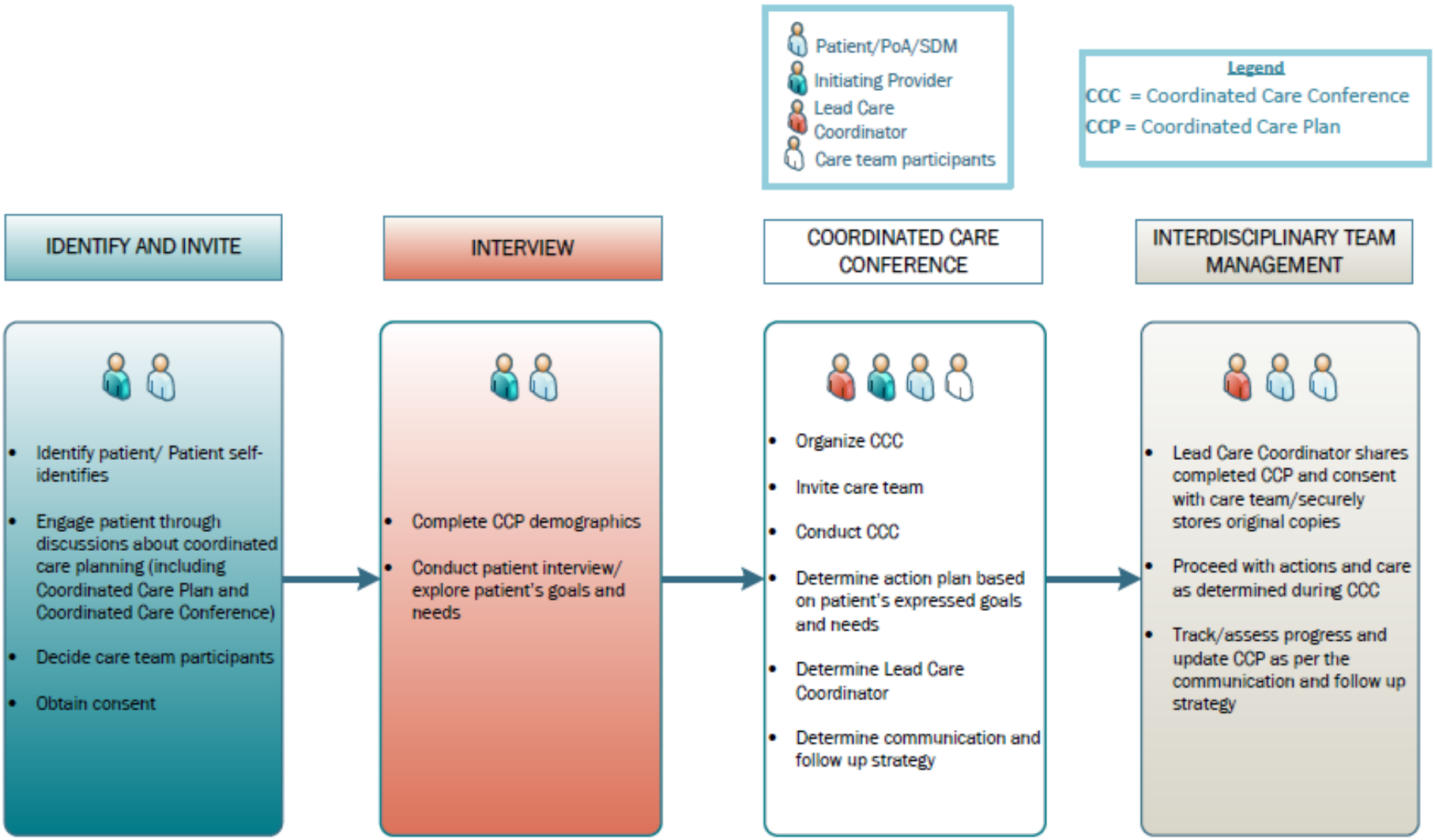
INDIVIDUAL AND PRIMARY CARE PHYSICIAN

INDIVIDUAL AND RESPIROLOGIST

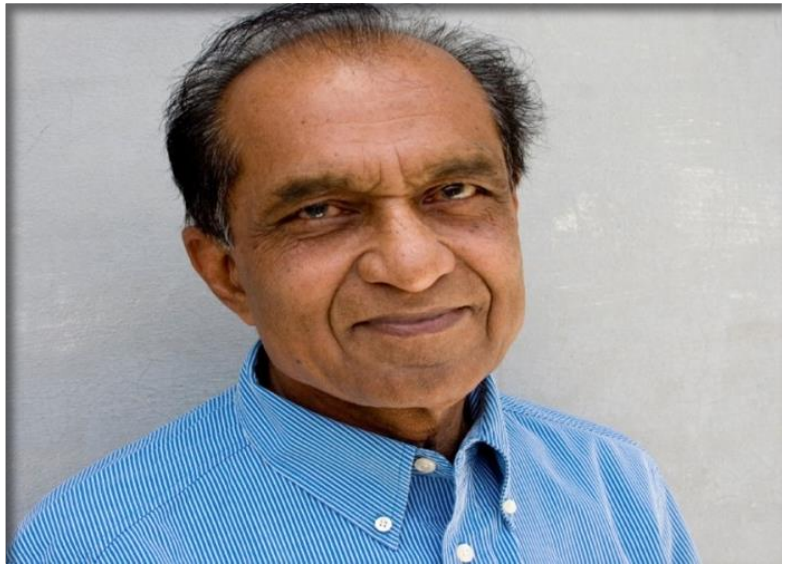
INDIVIDUAL AND CARE COORDINATOR

INDIVIDUAL AND MENTAL HEALTH ADDICTIONS NURSE

Health Links
Coordinated Care Planning Process



What does the Health Links Approach Plan to Achieve?



Coordinated care planning is meant to support your overall wellness. It considers your “whole person” needs – mentally, physically, emotionally, and spiritually. Think about cultural or community support people that you would want included on your Care Team to help support this “whole person” approach (e.g. spiritual support, traditional healer, naturopath, neighbour, friends, etc.)

Improving the Patient Experience

The patients' journey through the health care system will be improved through more effective communication with their Health Care Providers and more involvement in decision making.

By having a Coordinated Care Plan, patients with complex health care needs will benefit by not having to continuously repeat their health story or answer the same questions every time they require care.

Improving the Provider Experience

- Greater support for care coordination for patients that providers worry about the most
- Having a designated lead care coordinator within the patient's care team to help organize various health care services and supports
- Health Links aims to reduce avoidable office and ED visits, as well as the utilization of other services that reduce continuity of care such as, walk-in clinics

Health Link Lead Organization Considerations

- Who can lead a Health Link?
  - Hospital
  - Primary Care Team (FHT, Nurse Practitioner-Led Clinic, Aboriginal Health Access Centre, Community Health Centre or FHO)
  - Local Health Integration Network (LHIN)

- Lead Organization Roles and Responsibilities
  - Accountable to the LHIN for the Health Link's performance and responsible for achieving outcomes
  - Responsibility can be shared with other Health Link partner organizations

Who Should be Part of the Care Team?

Any person/organization involved in the individual's care; the individual helps to decide. It could include:

- 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)

Components of the Coordinated Care Plan

Page 1

- My Identifiers
- What's Most Important to Me and My Concerns
- My Care Team
- Health Care Consent and Advance Care Planning


HealthLink

[Insert Name]'s Coordinated Care Plan

Note: this template must be completed in conjunction with the Coordinated Care Plan user guide.

My Identifiers

What's Most Important To Me and My Concerns

My Care Team (include active family/caregivers, providers)

Health Care Consent and Advance Care Planning

Page 2

- My Health
- More About Me
- My Goals and Action Plan


HealthLink

[Insert Name]'s Coordinated Care Plan

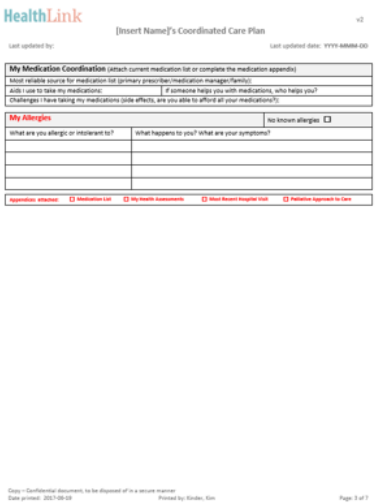
My Health (include physical health, mental health and addictions [i.e. smoking], functional issues, assistive devices)

More About Me

My Goals and Action Plan

Page 3

- My Medication Coordination
- My Allergies


HealthLink

[Insert Name]'s Coordinated Care Plan

My Medication Coordination (attach current medication list or complete the medication appendix)

My Allergies

Appendix 1

- My Medication List


HealthLink

[Insert Name]'s Coordinated Care Plan

Appendix 1

It is recommended to obtain the most recent medication reconciliation from provider/source where it was most recently completed (e.g. pharmacy, hospital, primary care)

My Medication List

Components of the Coordinated Care Plan

Appendix 2
- My Health Assessments


HealthLink
[Insert Name]'s Coordinated Care Plan
Appendix 2
My Health Assessments
Assessment type and name | Date completed | Notes
YYYY-MMM-DD

Appendix 3
- My Most Recent Hospital Visit


HealthLink
[Insert Name]'s Coordinated Care Plan
Appendix 3
My Most Recent Hospital Visit
Hospital name:
Visit date: YYYY-MMM-DD
Reason for visit:
Visit description: ☐ Emergency room to home ☐ Emergency room to inpatient unit
Date of discharge: YYYY-MMM-DD
Length of stay:
Comments:

Appendix 4
- Palliative Approach to Care


HealthLink
[Insert Name]'s Coordinated Care Plan
Appendix 4
Palliative Approach to Care
The person most responsible for my palliative care is:
Physical support plan (pain management, shortness of breath, constipation, nausea and vomiting, fatigue, appetite, drowsiness)
Symptoms | Treatments | Comments
Psychological support plan (emotion, anxiety, depression, autonomy, fear, control, self-esteem)
Symptoms | Treatments | Comments
Social support plan (relationships, family caregiver, volunteers, environment, financial, legal):
Spiritual support plan (values, beliefs, practices, rituals):
Preferred place of death:
Grief and bereavement support:
Other:

Participating in Coordinated Care Planning

As a member of the Care Team, you may be asked to:

- Complete sections of the Coordinated Care Plan
- Participate in a Coordinated Care Conference
- Work collaboratively with the patient and the Care Team to assist the patient in achieving the goals identified in the Coordinated Care Plan

For More Information

Ministry of Health and Long-Term Care

www.health.gov.on.ca