HealthLinks

Health Links Toolkit

April 2017

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Who should use this Toolkit?

This Toolkit is for any individual or organization who will be participating/facilitating the Health Links approach to care and hopes to better understand coordinated care planning.

What is the purpose of the Toolkit?

This Toolkit will give an overview of the Health Links philosophy and methodology and discuss the Coordinated Care Plan in detail.

1.0 Background

There are growing demands on Ontario's health care system. Complex health issues, financial strain, and siloed systems of care are creating challenges for those receiving the care, their caregivers, and health service and social service providers. Through the Health Links approach to care, improvements to the quality of care and the patient experience through the health care system are sought, while also reducing waste at the system level to create a collaborative network of care.

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 approach also promotes health equity by supporting patients to reach their full health potential and receive high-quality care that is appropriate to them and their needs, no matter where they live, what they have, or who they are.

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. Collaboration in care will result in Coordinated Care Plans that are patient-centered and written in their own words. This ensures that the patient's goals are effectively identified and a plan to achieve them is in place.

1.1 What Health Links Will Achieve

For Patients

The Health Links approach to care provides many benefits for patients living with complex chronic conditions, including: 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.

For Primary Care Providers

Benefits of the Health Links approach to care for primary care providers include:

- 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.

For Collaborating Care Team Providers

Benefits of the Health Links approach to care for collaborating care team providers include:

- Providing a broader perspective and understanding about what the patient is experiencing
- Greater efficiencies and potential for partners to become specialized in their roles
- Understanding of roles and responsibilities of each member of the Care Team, leading to enhanced knowledge about what each provider is doing to support patient goals
- The opportunity to work in a team with a range of health and social service providers
- The opportunity to develop relationships with contacts both internal and external to primary care
- Greater alignment across Ontario through the implementation of standard processes, tools and communication materials that are recognized and followed by providers to support seamless patient care

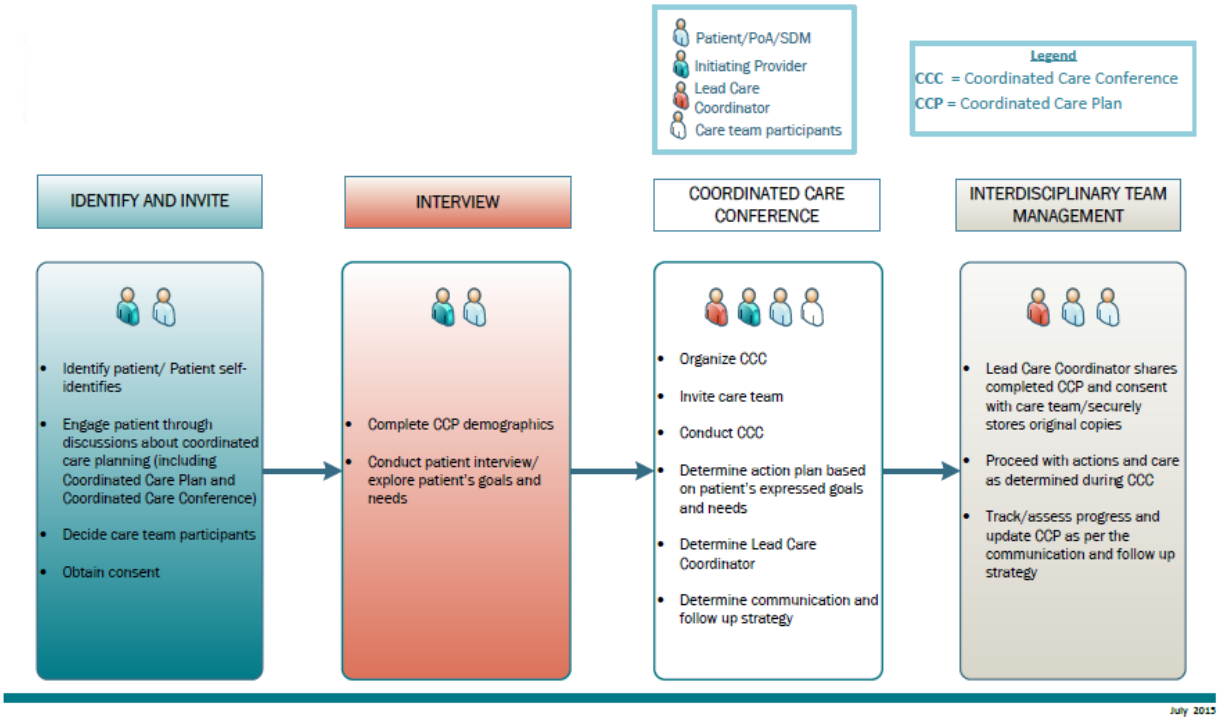
For the Health System

Benefits of the Health Links approach to care for the health system include:

- Stronger linkages with primary care for patients with most complex care needs
- More efficient use of limited resources
- Minimizing the number of services used by an individual patient

2.0 Coordinated Care Plan Framework

The Coordinated Care Plan Framework is depicted below.



3.0 Identify and Invite

3.1 Patient Guidelines

The following guidelines can be utilized when considering who might benefit most from a Coordinated Care Plan:

- Target population: People living with 4 or more complex or chronic conditions
- Identified sub-groups:
    - Those with Mental Health and Addictions challenges
    - Palliative population
    - People who are frail
- 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

3.2 Educating the Patient

Coordinated care planning may be a new concept for patients and their families. Resources for patients have been created to explain Health Links, the Coordinated Care Plan and how patients may benefit from having a Coordinated Care Plan and are available from local LHINs.

4.0 The Coordinated Care Plan

4.1 Definition of the Coordinated Care Plan

The Coordinated Care Plan (CCP) is at the heart of the Health Links approach to care. The CCP is focused on the goals set out by the patient.

To understand the Health Link's philosophy, it is important to understand:

- definition of the CCP
- why the CCP is important
- the purpose of the CCP
- how to complete a CCP
- interview techniques during the first meeting with the patient

The Coordinated Care Plan is a standardized form that was created by a cross-sector, interdisciplinary focus group with province-wide representation in conjunction with the Ministry of Health and Long-Term Care (MOHLTC). The CCP is a written or electronic plan created with the patient and is written in their own words, from their perspective.

This is evident if one looks at the following portion of the CCP:

My plan to achieve my goals for care		
What is most important to me right now?		
What concerns me most about my healthcare right now		
What I hope to achieve	What we can do to achieve it	Who will be responsible

It is up to the patient to set their healthcare priorities and the Health Link team will work with them to achieve those goals and to bring the appropriate health care partners to the table.

A Coordinated Care Plan outlines the patient's short and long-term needs, recovery goals and care coordination requirements and it identifies who is responsible for each part of the plan. The CCP contains medical and psychosocial information gathered from multiple sources.

The CCP collects a great deal of information about the patient's medical history as well as their healthcare goals. Some of the topics covered include:

- patient goals and care plan
- planning for future situations
- care team members
- health conditions and issues
- social history
- assessments
- recent hospital visits
- social supports

- medications
- other treatments
- key daily routines
- upcoming appointments

4.2 Purpose of the Coordinated Care Plan

The coordinated care plan serves several purposes including:

- coordinating care to prevent duplications and gaps in care
- acts as a guide that will assist the patient to achieve their healthcare goals
- reduces visits to emergency departments and hospital admissions
- connects patients with service agencies that will help provide the care and assistance they may require
- ensures communication between healthcare providers

All of these points focus on improving the quality of service and the health outcomes for the Health Links patient.

Since the CCP is written in the patient's words and is truly their plan. This creates a sense of ownership of their healthcare goals and their Coordinated Care Plan. This is especially important due to the fact that patients with complex needs often feel marginalized by the healthcare system and feel that their voices are not heard. The CCP outlines their health care plan and allows them to share the document with their healthcare providers. This helps them to communicate their goals and also demonstrates that they are taking steps to improve their health and well-being.