Identifying Patients for Coordinated Care Planning

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

Who might benefit from the Health Link approach to care and development of a Coordinated Care Plan?

- Individuals living with 4 or more complex or chronic conditions.
- Individuals with Mental Health and Addictions challenges.
- Palliative population.
- Individuals 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 judgement.

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Who is involved?

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 organization, specialist, hospital, long-term care home, and others work as a team, individuals with multiple, complex conditions receive better, more coordinated care. Working together, patients, families and providers, design individualized Care Plans to ensure they are supported to reach their goals and receive the support and care they need.

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HealthLinks

Ontario
Local Health Integration Network

What is Health Links?

Health Links is integrated across sub-regions as a patient-centered approach to care that focuses on enhancing and coordinating care for individuals living with multiple, chronic conditions and complex needs.

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

What is the Health Links approach?

The approach promotes health equity by supporting individuals 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.

What does the Health Links approach aim to achieve?

The Health Links approach provides 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.

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

What can friends and family of patients expect?

- The Health Links approach to coordinated care planning will help an individual get personalized, coordinated care they need, in the right place, at the right time.
- The patient, family member/friend, health and social service providers are part of the full Care Team.
- The care plan provides information of the patient's medical history, members of the Care Team and medication reconciliation.

What are the benefits for providers?

Health Links approach to care provides greater efficiencies and potential for health system partners to become specialized in their roles, build relationships with contacts both internal and external to primary care. The care plan provides better understanding to providers on how they each best support the patient with many care needs.

What are the benefits to patients?

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

- Care being focused on the patient's goals,
- Providers having a consistent understanding of their patients' health.
- 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.
- Individuals and their families/caregivers are partners with health and social service providers in the care coordination process.