Identifying Patients for Coordinated Care Planning

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

- Individuals living with four 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 judgment.

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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.

Contact Information

HealthLinks

Ontario
Local Health Integration Network

What is Health Links?

Health Links coordinates health care services for individuals with complex needs, especially seniors. By linking health care providers with patients, a patient-centered solution through community Health Links will improve transitions between primary care providers, specialists, hospitals, home care, long-term care and community agencies.

Health Links coordinates care for individuals with multiple conditions who see many different providers that can result in a lack of coordination in care delivery.

What is the Health Links approach?

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

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

The Health Links approach to care encourages health and social service providers to work together more closely in order to coordinate care with patients and their families.

What can friends and family of patients expect?

- The Health Links approach to coordinated care planning would help you, as a caregiver, to ensure your family member/ friend is getting the personalized, coordinated care they need in the right place, at the right time.
- You and your family member/friend, health and social service providers, and other supports are part of the full Care Team and will be included in the care coordination process.
- The care plan will reduce the need to repeat information.

What are the benefits to patients?

Your Health Links Care Coordinator will help you navigate the health system and will be your care partner, resource, and primary point of contact. You can chose your Lead Care Coordinator.

Your Coordinated Care Plan will enable your care team to work towards health goals that matter to you, and will ensure that your needs/ goals are very clear to everyone involved in your care.

All members of your health care team, including hospital staff, will have access to the same information. This helps them provide the right care, at the right time, and at the right place for you.