HealthLinks

Frequently Asked Questions

What is Health Links?

The Health Links approach intends to improve communication and collaboration among providers who share in the care of people with high care needs, the 5% of the population who use about 66% of health care resources. Multiple providers, appointments and complex care issues can make it difficult to meet these individuals' needs. A more collaborative approach to providing care can be achieved through a process called "Coordinated Care Planning."

What is Coordinated Care Planning?

Coordinated care planning (CCP) aims to bring local health and social service providers together, with patients/clients and their families, to develop a care plan based upon the individual's goals. This care plan allows for more coordination and faster follow-up when people transition from one provider to another, allowing people to live well in their community and reduce avoidable healthcare utilization.

What is the plan for implementation?

In the South West LHIN, the Health Links approach is in various stages of implementation:

Sustainability and Spread Phase	Huron Perth
Implementation Phase	London Middlesex North Grey Bruce South Grey Bruce
Planning Phase	Oxford Elgin

Each Health Link geography follows a Ministry of Health and Long Term Care (MOHLTC) Business Planning template to detail its plans for implementation, collecting input from many organizations across its region. Through the establishment of local Health Links Steering Committees and Working Groups, a sustainable plan is typically implemented over a two-year period. At the South West LHIN level, a Health Links Leadership Collaborative has been established, in order to facilitate consistency in principles and approach, as appropriate.

Which organizations should be involved?

Health and social services included in planning and implementation may include the following: Primary Care, South West Community Care Access Centre (SW CCAC), ConnectingSouthWestOntario (cSWO), Hospital, Mental Health and Addictions, Public Health, Long Term Care, Community Support Services, Behavioural Supports Ontario (BSO), Partnering for Quality, Aboriginal Health Services, Hospice Palliative Care, South West Local Health Integration Network (SW LHIN), Social Services (e.g. Housing), and Emergency Medical Services (EMS).

The involvement of patients and families in planning and implementing the Health Links approach to coordinated care planning is strongly encouraged. Organizations from any health and social service are welcome to become involved.

What are the roles and expectations of organizations who become involved?

Organizations may become involved at any level of planning or implementation, including membership in the Steering Committee, Working Group, or Coordinated Care Planning Team, at the patient/client level. Roles and expectations vary across steering committees and working groups, as indicated in their Terms of Reference. Individuals who assume the Lead Navigator/Coordinator for a coordinated care plan, at the patient/client level, are responsible for ensuring that:

- the patient/client understands the Lead Navigator/Coordinator role,
- any transitions between leads occurs smoothly,
- updates/changes to the coordinated care plan (CCP) are communicated to the care team, and
- regular follow-up occurs with the patient/client, at intervals agreed upon by the patient/client and the care team.

All care team members involved in an individual's CCP are responsible for:

- those actions agreed upon within the CCP (including fulfilling their portion of system navigation for the patient/client),
- notifying the Lead Navigator/Coordinator of any requirements to update the CCP, and
- informing other providers within their own organization about updates in status/planning for the individual.

How does an organization become involved, if not already?

Contact local implementation teams:

Huron Perth	huronperthhealthlink@npfht.ca
London Middlesex	healthlink@thamesvalleyfht.ca
South Grey Bruce	healthlink@sbghc.on.ca
North Grey Bruce	NGBHL@osfht.ca -
Oxford	oxfordhealthlink@cmhaoxford.on
Elgin	elginhealthlink@eefht.ca

What does shared accountability look like, including cross organization/sector?

At the geographical local Health Link level, all providers share the responsibility for providing better, coordinated care for their citizens, contributing to the ability for people to live well in their community and minimizing avoidable healthcare utilization. Some of this shared accountability is demonstrated by shared organizational objectives (e.g. building collaborative relationships, formalizing cross-organizational partnerships) and metrics (e.g. reduced Alternate Level of Care, reduced hospital readmissions).

At the individual patient/client level, the full coordinated care planning team shares in the effort to support the individual to meet his/her personal goals, as agreed upon in the coordinated care plan.

How is a patient's information protected?

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

How is implementation of the Health Links approach funded?

The first 69 Health Link geographies were funded for both Business Planning and Implementation by the Ministry of Health and Long Term Care. Moving forward, funding for planning and implementation in new geographies and continued implementation of the Health Links approach will be distributed by the Local Health Integration Network (LHIN).

What ministries are involved in implementing the Health Links approach?

At the provincial level, the Ministry of Health and Long Term Care has been directly involved in funding and supporting the Health Links approach across the province. However, at the patient/client level, organizations/people supported by other ministries are most certainly involved in coordinated care planning (e.g. Ministry of Municipal Affairs and Housing).

What are both the intended and realized impacts of the Health Links approach?

The overall aim of the Health Links approach to coordinated care planning is to support patients and families, with high care needs, to be able to live well in their community and reduce avoidable healthcare utilization. We are tracking the following indicators:

- Number of Emergency Department (ED) visits before and after coordinated care planning
- Number of Hospital Admissions before and after coordinated care planning
- Number of People across the South West Local Health Integration Network (LHIN) who are supported by a coordinated care plan (CCP)
- The experience of patients/clients/family/supports

Based on early data, with 10 patients/clients, we have seen a decrease in ED visit and Hospital Admission rates following the CCP experience. In-depth interviews with patients/clients/families/support demonstrate an appreciation for the process and that patients/clients feel respected throughout the process.

How are social determinants of health, such as housing, considered and addressed as part of the Health Links approach?

Patient/client goals lie at the heart of the coordinated care planning (CCP) process. If the social determinants of health pose barriers/challenges to meeting those goals, the Care Team will work with the patient/client to best mitigate those challenges. The Care Team may be built/expanded, with support from the patient/client, to include members who might be most aware or can assist with access to resources such as social assistance, housing or transportation.

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How do people access the Health Links approach to Coordinated Care Planning?

The referral process for Health Links Coordinated Care Planning (CCP) varies slightly across the six different geographies across the South West Local Health Integration Network (SW LHIN). To find out more information about how to refer a patient/client for the CCP process, contact your local implementation team.

Huron Perth	huronperthhealthlink@npfht.ca
London Middlesex	healthlink@thamesvalleyfht.ca
South Grey Bruce	healthlink@sbghc.on.ca
North Grey Bruce	NGBHL@osfht.ca
Oxford	oxfordhealthlink@cmhaoxford.on
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What does a Coordinated Care Planning conference look like? Who is involved? Is the physician involved? Who leads the conference?

The patient/client helps to build his/her Care Team, which essentially determines who would be present for the Coordinated Care Planning (CCP) conference. The patient/client's primary care practitioner is typically part of the team and therefore, present for the conference. The Care Team typically meets with the patient/client/family face to face, in a setting that is most comfortable for the patient/client (e.g. their home, their primary care clinic). However, technology can be and has been leveraged to include people for whom face to face participation is difficult. For example, a specialist from an urban centre may join a conference in a rural setting via telephone or video conference. Additionally, for those patients/families who may find it difficult to leave home, they may participate with the assistance of someone from the care team via video conference technology.

The direction of the plan is truly led by the patient/client, based on his/her goals. From a facilitation perspective, the Lead Navigator/Coordinator typically leads the conference. The Lead Navigator/Coordinator is typically someone with an existing, trusting relationship with the patient/client or someone who can easily develop a new relationship.

How is the coordinated care plan shared? How is technology being used (e.g. ClinicalConnect)?

Implementation of electronic versions of the Coordinated Care Plan (CCP) varies across Health Link geographies. In some areas, the South West Community Care Access Centre (SW CCAC) is documenting all of the CCPs within their Client Health Information Record System (CHRIS). This approach allows those Care Team partners who can access Clinical Connect to see the electronic CCP as it is developed and updated. In the Huron Perth Health Link, some partners are trialing the provincial Care Coordination Tool (CCT), which allows those partners who are connected to the tool to review and update the electronic CCP in real-time. In other cases, the CCP is documented and updated in a Microsoft Office Word document. In many situations, not all partners can access an electronic version of the CCP. Therefore, updated paper versions of the CCP are provided/faxed to those team members, including the patient/client.

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If money is saved through the Health Links approach, will it be reinvested?

The Health Links approach to coordinated care planning is working to provide the right care, at the right time, in the right place, with the appropriate providers in a coordinated manner. If healthcare utilization is appropriately reduced, there will be more capacity in the system to meet the needs of others.