Communiqué to NE LHIN Hospital Chiefs of Staff – *NEW* Advanced Health Link Model

September 2015

Health Links are a model of care underway that started across the province in 2012. Within Health Links, all providers in a community – including primary care, hospital, and community care – work together to coordinate care plans at the patient level. Health Links are accountable to LHINs.

In June 2015, the Ministry of Health and Long-Term Care (MOHLTC) announced the introduction of the **Advanced Health Link Model**. Based on the learnings from 69 established Health Links, it establishes common standards going forward, including patient identification, common metrics, and the creation of a mechanism to share best practices.

Common Provincial Process to Identify Patients:

- Patients with four or more chronic/high cost conditions, including a focus on mental health and addictions (MHA) conditions, palliative, and frail elderly;
- Economic characteristics (low income, median household income, unemployment);
- Social determinants of health (housing, living alone, language, immigration, community and social services, etc); and
- Focus on adaptation of care planning for vulnerable populations (mental health and addictions, frail elderly, palliative) to support a strategic focus.

New Metrics for an Advanced Health Link:

- Continue reporting on number of care plans and attachment to primary care;
- Reduction of 30-day readmissions to hospital;
- Reduction in home care visits referral time; and
- Reduction in the number of ED visits for conditions best managed elsewhere.

NE LHIN: Seven Health Links in Various Stages:

- **Timmins Health Link** (Family Health Team is lead agency), has been active since 2013 and has developed care coordination plans for more than 60 patients.
- **Temiskaming Health Link** (CHC is lead agency), has been active since 2013 and has created more than 50 care coordination plans for patients.
- **North Cochrane Health Link** (CHC is lead) has just started and includes the communities of Hearst, Kapuskasing, Smooth Rock Falls and Iroquois Falls.
- **Sault Ste. Marie Health Link** (Group Health Centre is lead) has just started.
- **Nipissing-East Parry Sound Health Link (**West Nipissing General Hospital is lead) includes West Nipissing, Mattawa, North Bay, and Powassan, with a number of smaller communities in the East Parry Sound area. Recently approved, it will begin work shortly.
- **Greater Sudbury Health Link (CMHA is lead)** recently approved and will begin work shortly. The Greater Sudbury Health Link will have a large focus on patients with mental health and addictions conditions, as well as patients with a dual diagnosis.
- **East Algoma Health Link** -- not yet approved however actively under development**.**

Other Integrated Models of Care Underway:

- **Health Hubs:** Suited for rural areas, one provider in the community holds the accountability agreement and is responsible for delivering all services to the entire community.
- **Community Network:** Suited for rural areas as well, a Network develops care plans for an entire geographic area, not just the top 5%. One is underway on Manitoulin Island.
- **North East Communities Framework:** This NE LHIN developed framework helps community stakeholders determine an appropriate service delivery model to enhance patient care and transitions between hospital and community. The framework is being piloted as a two-year project in six North Algoma communities including Wawa, White River, Michipicoten First Nation, Missanabie, Hawk Junction and Dubreuilville.

Did you know?

The top 5% of patients account for two-thirds of health care costs. These are most often patients with multiple, complex conditions. The Advanced Health Link Model will continue to focus on this population group.

The MOHLTC has determined that 97.6% of all high-cost patients in Ontario have at least one of 53 conditions, which include:

- Mental health conditions, dementia, substance-related disorders, schizophrenia and delusional disorders, depression, bipolar, anxiety disorders, eating disorders, personality disorders, developmental disorders, brain injury
- Diabetes, heart disease, COPD, and other chronic diseases such as Crohn's Disease, liver disease, arthritis and renal failure
- Hip and knee replacements

Change Management: Health Links is a change management project supported by an electronic care planning tool, available to all EMRs, and a business intelligence tool to assist in real-time identification of Health Links patients.

For more information on Health Links and other integrated models of care, visit www.nelhin.on.ca or contact Jennifer MacKinnon, NE LHIN Primary Care Officer at Jennifer.MacKinnon@lhins.on.ca