

Health Links 101



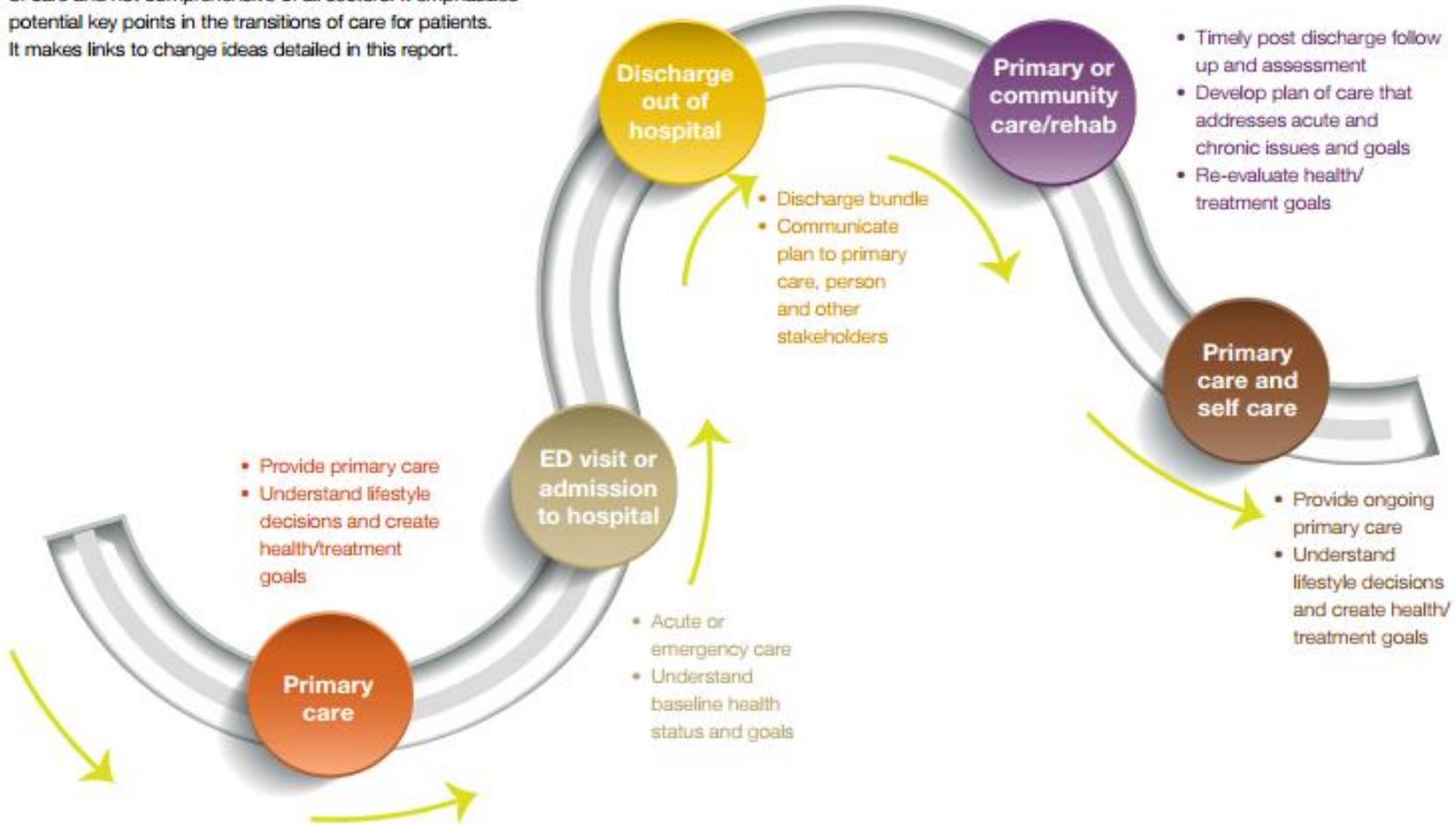
Ontario

Local Health Integration
Network

Réseau local d'intégration
des services de santé

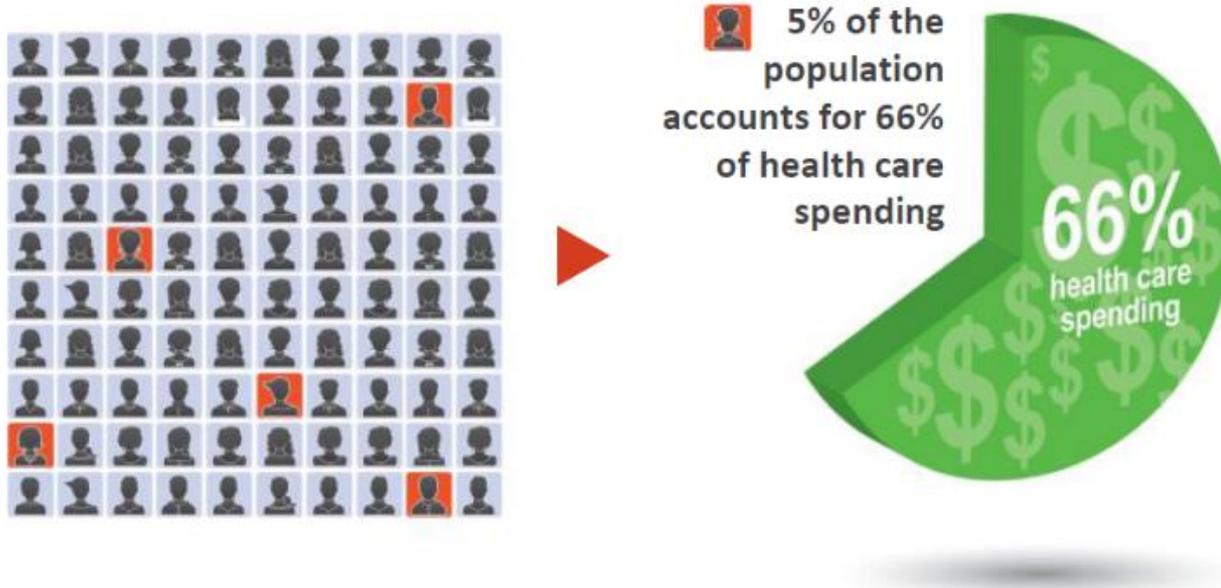
The Patient's Integrated Journey of Care

This diagram highlights examples of how potential episodes of care could be connected. It is just one example of a path of care and not comprehensive of all sectors. It emphasizes potential key points in the transitions of care for patients. It makes links to change ideas detailed in this report.



The case to support complex patients

The relatively few people with complex health problems account for the majority of our health expenditure



What is a Health Link?

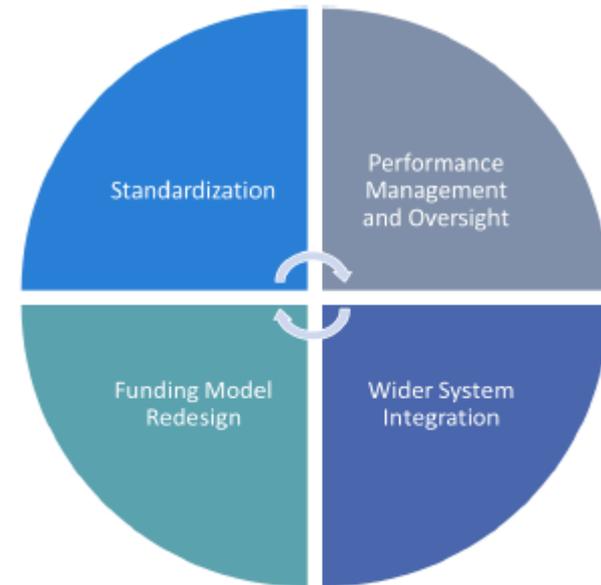
- Components of a Health Link
 - Patient-centred
 - Primary care, acute care, community care
 - Coordinated care
 - Partnerships across the continuum of care, beyond health care
 - Better communication
 - Change management
 - Inclusivity and equity of care to all patients
- Goal of a Health Link: *Individualized, coordinated care plans for complex patients*

How Health Links will Help

- For providers it means they will:
 - Work together with patients and their families to ensure the patient receives the care they need
 - Design an individualized, coordinated care plan for each patient in partnership with other health services providers who also provide services to their patient
 - Have real-time access to the care plan so everyone is aware of the patient's treatment plan and wishes, no matter where the patient seeks care
- For the patient it means they will :
 - Have an individualized, coordinated plan
 - Have care providers who ensure the plan is being followed
 - Have support to ensure they are taking the right medications
 - Have a care provider they can call who knows them, is familiar with their situation and can help.

Health Links Guiding Principles and Model

1. Regular and timely access to primary care for complex patients
2. Effective provision of coordinated care for all of Ontario's complex patients
3. Consistent, quality care across the health care continuum and social services sectors
4. Focus on vulnerable populations (**frail and elderly, mental health and addictions and palliative**).
5. Evidence-based, measurable improvement of the patient experience through enhanced transitions in care
6. Maximize coordinated care to generate system value, sustain the Health Links Model and strengthen care coordination processes to realize greater efficiencies
7. LHINs accountability for performance



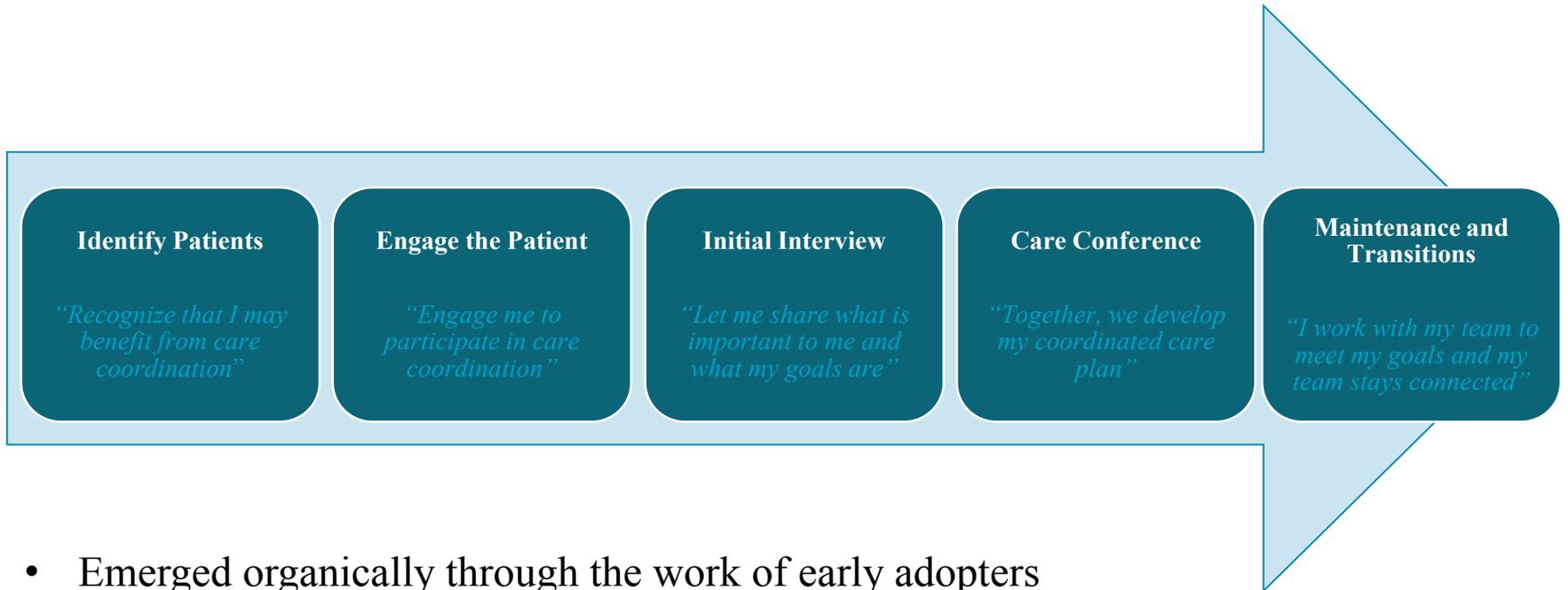
**IMPLEMENTATION - Over 2015/16
EFFECTIVE FOR ALL HEALTH LINKS -
2016/17**

Identifying Target Population

- Patient eligibility includes:
 - Patients with 4+ chronic/high cost conditions
 - Plus a focus on mental health and addictions, palliative patients, and the frail elderly
 - Economic characteristics (low income, unemployment)
 - Social determinants (housing, language, immigration, community and social services etc.)
 - Or at the Clinician's discretion that the patient could benefit from a coordinated care plan

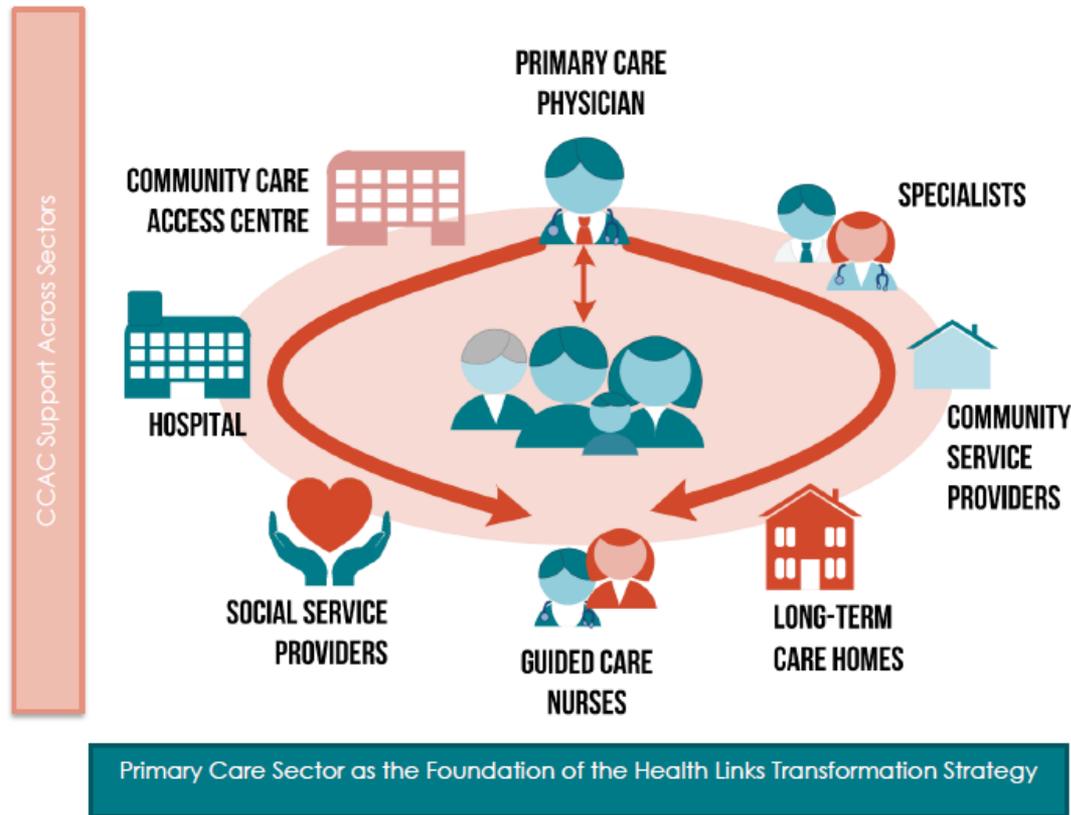
Source: 'Health Links Target Population' Webinar, The Ministry of Health and Long Term Care. August 12, 2015

The Coordinated Care Planning Process



- Emerged organically through the work of early adopters and emerging Health Links.
- Not mandatory- yet most Health Links have adopted or adapted some or all of these steps into their processes.
- Continues to evolve.

The Coordinated Care Planning Process



- Example of Care Coordination Process (Sault Ste. Marie Health Link)
- Guided Care Nurses, based on John Hopkins Model, support patients and families to connect services required

Process to create a Health Link

- Build community readiness – community tables, network meetings, etc
- As a community, submit a Readiness Assessment to the Ministry of Health - Choose a lead agency
- Once approved, create a Business Plan
- Once Business Plan is approved, begin pilot stage and evaluate
- Scaling up and sustainability of Health Link

Questions?

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