Ontario

BACKGROUNDER

Ministry of Health and Long-Term Care

About Health Links

December 6, 2012

Ontario is improving care for seniors and others with complex conditions through Health Links. This innovative approach brings together health care providers in a community to better and more quickly coordinate care for high-needs patients.

How will Health Links benefit patients?

When different health care providers work as a team to care for a patient, they can better coordinate the full patient journey through the health system, leading to better care for patients. Health Links will help to ensure that patients with complex conditions:

- No longer need to answer the same question from different providers.
- Have support to ensure they are taking the right medications appropriately.
- Have a care provider they can call, eliminating unnecessary provider visits.
- Have an individualized comprehensive plan, developed with the patient and his/her care providers who will ensure the plan is being followed.

How will Health Links work?

Health Links will encourage greater collaboration between existing local health care providers, including family care providers, specialists, hospitals, long-term care, home care and other community supports. With improved coordination and information sharing, patients will receive faster care, will spend less time waiting for services and will be supported by a team of health care providers at all levels of the health care system.

Health Links put family care providers at the centre of the health care system. By bringing local health care providers together as a team, Health Links will help family doctors to connect patients more quickly with specialists, home care services and other community supports, including mental health services. For patients being discharged from hospital, the Health Link will allow for faster follow-up and referral to services like home care, helping reduce the likelihood of re-admission to hospital.

All Health Links will have a coordinating partner such as a Family Health Team, Community Health Centre, Community Care Access Centre or hospital. Other members of the Health Link must be willing and able to collaborate in order to better and more quickly coordinate health care services for high-need patients such as seniors and others with complex conditions.

In order to establish a Health Link, strong representation from local primary care providers and the Community Care Access Centre is required. Joining or establishing a Health Link is voluntary.

How will the results of each community's Health Link be measured?

Health Links will share information, including through Electronic Health Records, and measure results while working with their Local Health Integration Network (LHIN) to achieve short- and long-term goals, starting with:

- Developing coordinated care plans for complex patients.
- Increasing the number of complex and senior patients with regular and timely access to a primary care provider.

Over time, better access and care for patients will result in improvements such as:

- Reduced unnecessary hospital admissions and re-admissions within 30-days of discharge.
- Reduced avoidable Emergency Department visits for patients with conditions best managed elsewhere.
- Same day/next day access to primary care.
- Reduced time from a primary care referral to specialist consultation for complex patients.
- Reduced time from referral to first home care visit.
- Reduced alternate level of care (ALC) days in hospital.
- An enhanced experience with the health care system for patients with the greatest health care needs.

Why are Health Links needed?

Health Links are a new way of coordinating local health care for patients who often receive uncoordinated care from several different providers, resulting in both gaps and duplication in the care provided.

Coordinating care is an important step in improving the services available to patients with complex conditions. Typically, these patients are seniors, have multiple chronic diseases and mental illness. These patients often default to the emergency department for care and are repeatedly re-admitted to hospital when they could be receiving care in the community.

A recent study found that 75 per cent of seniors with complex conditions who are discharged from hospital receive care from six or more physicians and 30 per cent get their drugs from three or more pharmacies. The result is decreased patient care that also costs the health care system more than it should.

Patients with the greatest health care needs make up five percent of Ontario's population but use services that account for approximately two-thirds of Ontario's health care dollars. Better coordination of care for these patients will result in better care and significant health system savings that can be devoted to other patients, ultimately improving the sustainability of public health care.

How will the Ministry of Health and Long-Term Care support Health Links?

Each Health Link will be required to submit a business plan to the ministry and the LHIN to show how it will achieve short and long-term goals. The ministry and the LHIN will provide assistance to develop and implement this plan, as will other key partners like Health Quality Ontario and eHealth Ontario.

The ministry will also provide dedicated assistance to each Health Link in order to work through issues and provide flexibility to break down barriers to providing better care.

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