## What are the benefits for providers?

Benefits for providers include:

- Greater support for care coordination for patients that providers worry about the most
- Having a designated lead care coordinator within the patient's care team to help organize various health care services and supports
- Health Links aims to reduce avoidable office and ED visits, as well as the utilization of other services that reduce continuity of care such as, walk-in clinics

## 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

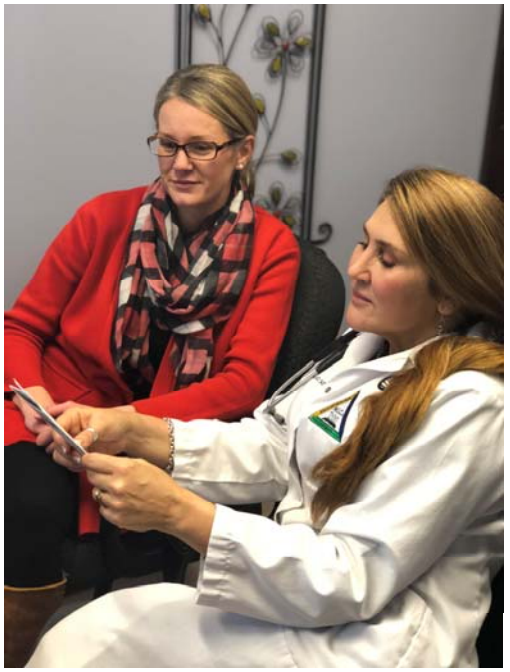
- You and your family member/friend, health and social service providers, and other supports are part of the full Care Team and will be included in the care coordination process
- Coordinated care planning will ensure you have the support you need to help your family member/ friend with their care needs
- Sharing the care plan will reduce the need to repeat information to different providers

# HealthLinks

**For more information please contact: The Health Link Program Coordinator or A Health Link Care Coordinator at:**

**Phone:**
**705-258-2818**

**Email:**
**healthlink@iffht.com**



# HealthLink

MICs Health Link

Let's Make Healthy Change Happen

## What is the Health Links approach?

Health Links will be integrated across sub-regions as a **patient-centered approach to care** that focusses on enhancing and coordinating the care for patients living with multiple chronic conditions and complex needs.

The approach also promotes health equity by **supporting patients 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.

## 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 organizations, specialists, the hospital, the long-term care home and others work as a team, patients with multiple, complex conditions receive better, more coordinated care. **Working together, providers design individualized Care Plans with patients and their families** to ensure they are supported to reach their goals and receive the support and care they need.

## Identifying Patients for Coordinated Care Planning

The following guidelines can be utilized when considering who might benefit most from a Coordinated Care Plan:

- Target population: People living with 4 or more complex or chronic conditions
- Identified sub-groups:
  - Those with Mental Health and Addictions challenges
  - Palliative population
  - People 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

## 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 patients with complex needs**, by ensuring each patient 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 are the benefits to patients?

The Health Links approach to care provides many benefits for patients living with complex chronic conditions, including:

- Care being focused on the patient's goals
- Providers having a consistent understanding of their patients' conditions
- Easier navigation of health care services
- Patients feeling more supported in their health care journey, having fewer visits to hospitals, and focusing on improved quality of life.