

Why Health Link?

Patient/clients living with complex health issues benefit from more integrated and coordinated care. This works to ensure the best health outcomes possible.

Health Link supports providers in delivering a coordinated and integrated approach to care for their patients.

Coordinating care supports health care providers involved in a patient/client's care to:

- Understand what is most important to the patient/client and caregiver in achieving their goals
- Participate in team discussions with patients/clients about how to best achieve their goals
- Communicate on an ongoing basis to monitor and understand changes to the patient/client's care plan

What is Health Link?

Ontario is improving care for people with complex conditions through Health Links. This innovative approach brings together health and other social service providers to better and more quickly coordinate care for high-needs patients.

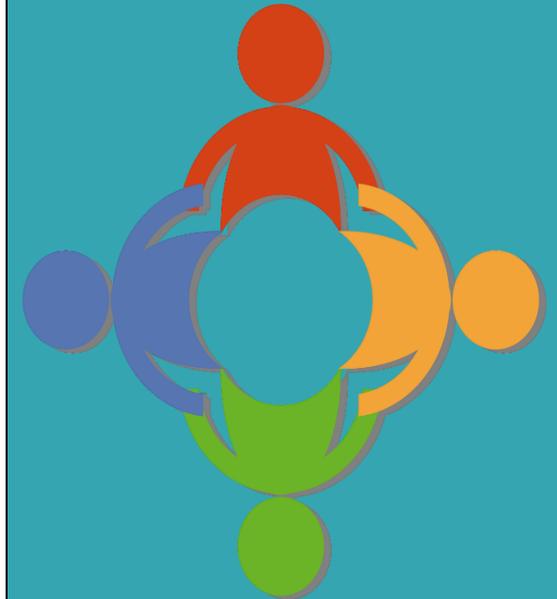
What does Health Link do for patients?

- Supports providers to work with each other and the patient/client to develop a documented individualized Coordinated Care Plan (CCP)
- Determines a provider responsible for taking the lead in coordinating care who works in partnership with other providers
- Facilitates access to primary care and supports attachment
- Fosters relationships in a patient/client's circle of care to enable ongoing communication and collaboration in the provision of care

HealthLink

Let's Make Healthy Change Happen

Working Together for Coordinated Care



HealthLink

Let's Make Healthy Change Happen

Coordinated care reduces gaps in the care of patient/clients with multiple chronic conditions.

Poorly coordinated care has been identified as a significant cause of adverse health outcomes and rising health care costs.

As a health care provider, you play an important role in planning and organizing your patient/client's care. Health Link can assist you in ensuring coordinated care for your complex patients/clients.

How the Process Works:

- 1. A patient/client is identified as having complex health care issues that would benefit from coordinated care and they are invited to participate.**

The target population definition for Health Links is patients with 4+ chronic conditions, with consideration to social and economic factors affecting health.

- 2. The patient/client is engaged regarding their health care goals and to identify their care providers.**

Identification of patient/clients' goals is central to the process. A lead care coordinator is identified – a variety of providers may play this role. The circle of care is also identified so they can be engaged in the care planning process.

- 3. The providers and patient/client are invited to participate in a care conference, in person or by teleconference, and the Care Plan is completed and updated as needed.**

The lead is responsible for facilitating the care conference. The care plan is shared and then kept up to date by the lead who receives updates from the care team. Communication is ongoing and progress is monitored.

What is unique about coordinated care planning/Health Link?

- Health care is focused on the patient/client's goals and what is most important to them.
- There is a specific person responsible for leading coordinated care planning for each individual patient.
- A Coordinated Care Plan (CCP) is developed which integrates input from all members of the care team and the patient. Team discussions clarify roles of team members in helping the patient/client achieve their goals.
- The CCP is shared with the circle of care, including the patient/client. The patient/client and providers understand the responsibilities of each provider and how to contact them.
- Health Link results in improved integration of care, smoother transitions between providers, and better health outcomes and experience for patient/clients.

For more information, contact the Health Link Project Manager

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Fax Health Link Referral Form

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