Central East Health Links

Let’s Make Healthy Change Happen

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What is a Health Link?

A Health Link is a local health care network consisting of patients, caregivers, Health Care Providers and Community Support Service agencies who are committed to working better together to improve the health outcomes for patients with complex health care needs.

Through enhanced collaboration among Health Link networks, patients with complex health care needs, along with their Health Care Providers, will develop individual Care Plans that more effectively meet their goals and ensure smoother transitions between care providers.

"**Health Links** are 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 hospital, the family doctor, the long-term care home, community organizations and others work as a team, patients with multiple, complex conditions receive **better, more coordinated care**. Providers design individualized Care Plans, and work together with patients and their families to ensure they receive the care they need."

Ministry of Health and Long-Term Care
February 2015

Patients First:
Action Plan for Health Care

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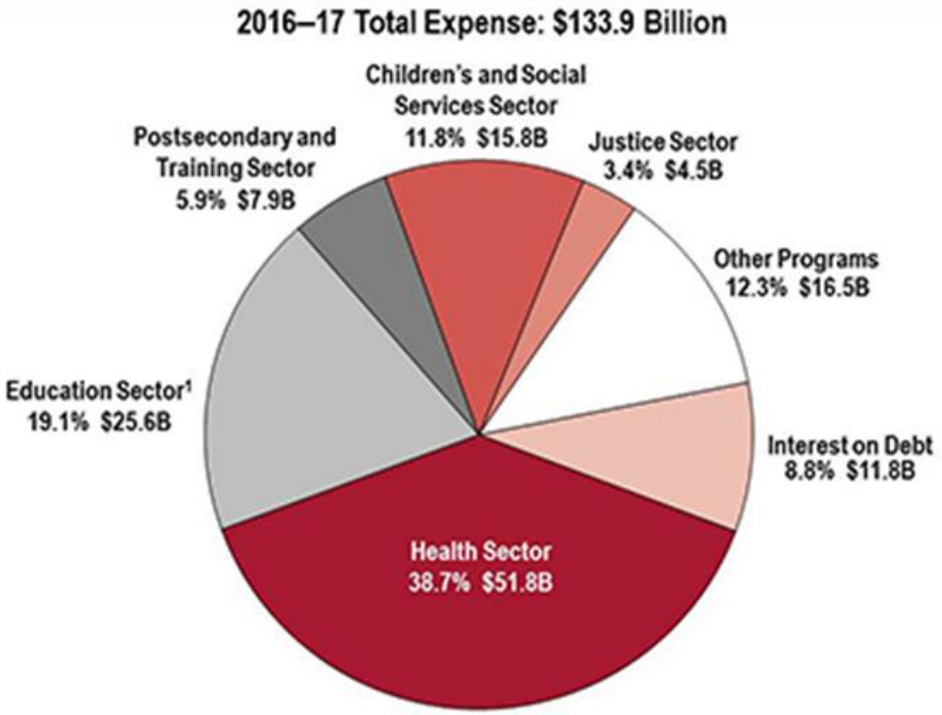
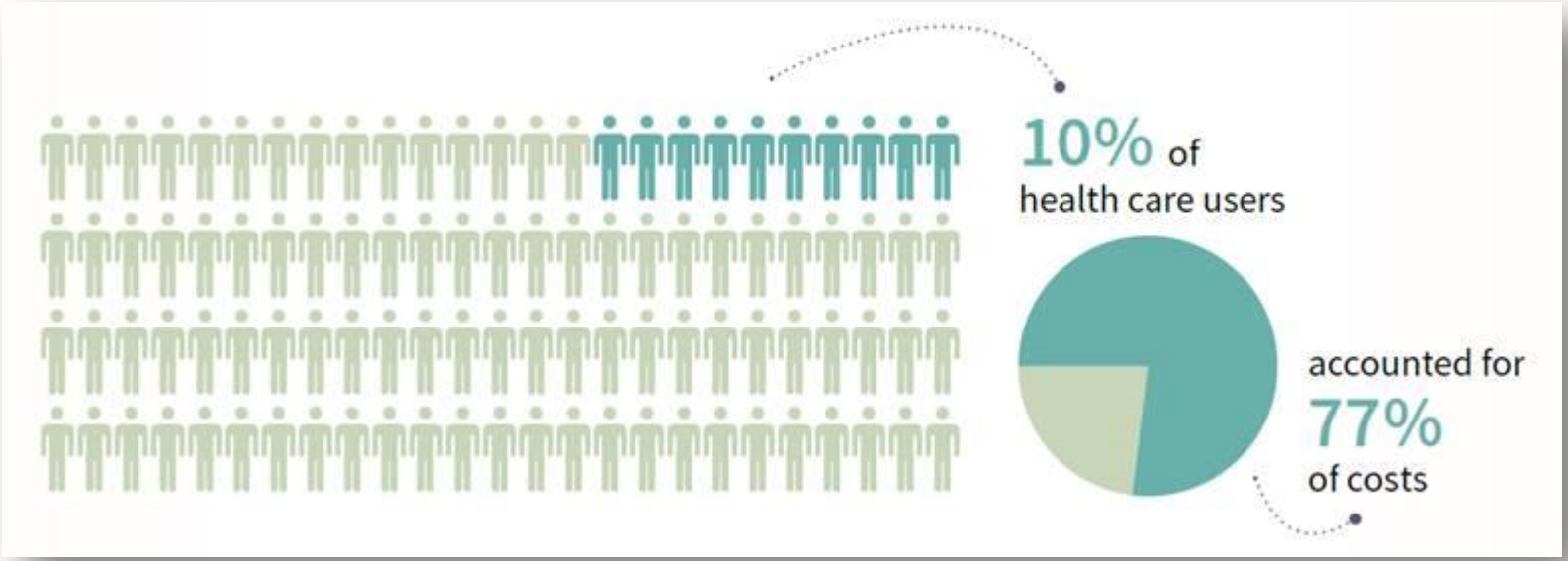
Provincial Expense Distribution

CHART 3.24 Composition of Total Expense, 2016–17



[1] Excludes Teachers' Pension Plan. Teachers' Pension Plan expense is included in Other Programs.
Note: Numbers may not add due to rounding.

Proportion of Health Care Expenditures in Ontario



Source: Wodchis WP, Austin PC, Henry DA. A 3-year study of high-cost users of health care. CMAJ 2016 Jan. 11

With no changes, the impact of demographics alone would add $24 billion in spending within 20 years, 50% increase, not including inflation.

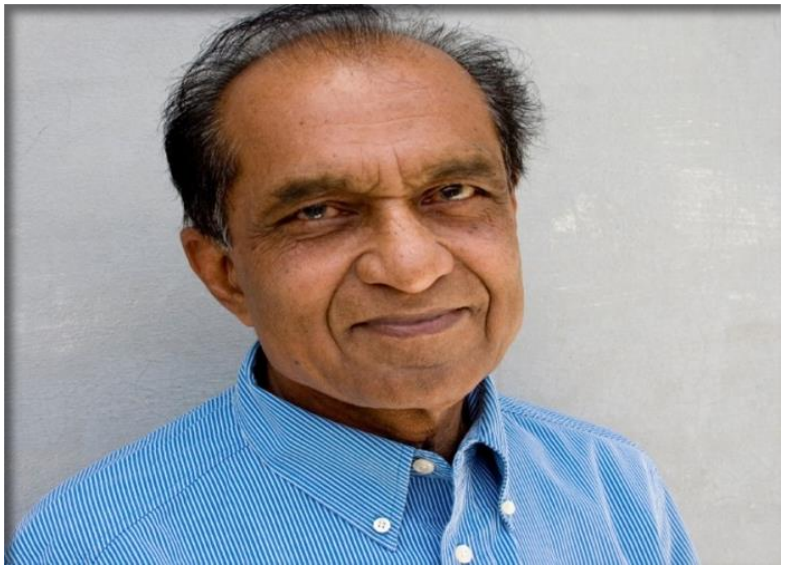
Target Population

The Health Links target population focuses on the top 5% of Ontario's Complex patients. Health Links patients experience four or more chronic/high cost conditions including:

- **Vulnerable populations** (focus on mental health and addictions conditions, palliative patients, and the frail elderly)
- **Economic characteristics** (low income, median household income, government transfers as a proportion of income, unemployment)
- **Social determinants** (housing, living alone, language, immigration, community and socials services etc.)
- **Complex, high needs patients**

What do Health Links Plan to Achieve?

Over time, the Health Link approach aims to achieve the best possible health outcomes and enrich the patient's experience of the health care system by reducing wait times, visits to the emergency department, and unnecessary hospital readmissions.



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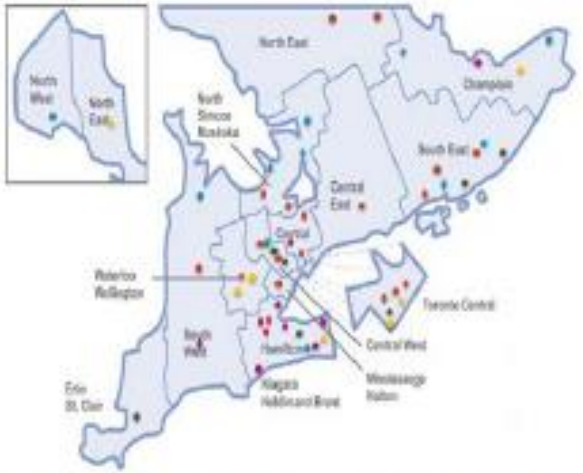
What has been done to date?

9,233

CARE PLANS PRODUCED



1,800 Partners are engaged across health, community and social services sectors

Central East Health Link Communities

HealthLink
Durham North East
Let's Make Healthy Change Happen

HealthLink
Durham West
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HealthLink
Scarborough North
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HealthLink
Scarborough South
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HealthLink
Peterborough
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HealthLink
Northumberland
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HealthLink
Haliburton County and City of Kawartha Lakes
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Central East Communities Snapshot

As a geography, a Health Link defines the community of patients to whom efforts and resources will be directed.

The specific size and population for each Health Link is as follows:

Cluster	Health Link	Km2	%	Pop.	%	Density/k2
DURHAM	Durham West	449.1	2.7	320,400	21.1	713
	Durham North East	2,172.1	13.0	287,800	19.0	132
NORTHEAST	Haliburton County & City of Kawartha Lakes	7,893.8	47.3	89,310	5.9	11
	Northumberland	1,766.9	10.6	72,475	4.8	41
	Peterborough	4,215.2	25.3	135,085	8.9	32
SCARBOROUGH	Scarborough North	42.4	0.3	178,395	11.7	4,207
	Scarborough South	138.3	0.8	434,815	28.6	3,144
Totals		16,667.8	100.0	1,518,280	100.0	(Avg.) 91

Benefits of Health Links

- Improved communication between patients/caregivers, primary care providers, hospitals, homecare, and community agencies
- Improved patient and family satisfaction
- Better health outcomes and quality of life
- Easier transitions to/from hospitals and other services
- Increased efficiencies in the health care system
- Activities are directed by community and population needs

Reporting Requirements

Currently Health Links are reporting to the Ministry of Health and Long-Term Care on two indicators:

- **Coordinated Care Plans (CCPs):** Number of patients with a Coordinated Care Plan developed through the Health Link

- **Access to Primary Care Provider (PCP):** Number of patients with regular and timely access to a Primary Care Provider

Improving the Patient Experience

The patients' journey through the health care system will be improved through more effective communication with their Health Care Providers and more involvement in decision making.

By having a Coordinated Care Plan, patients with complex health care needs will benefit by not having to continuously repeat their health story or answer the same questions every time they require care.

Improving the Provider Experience

- Collaborative care that effectively meets patient goals
- Improving patient safety by reducing risks and dissatisfaction associated with fragmented care
- Increased access to up-to-date information about your patient
- Improved ability to communicate and problem solve with an interdisciplinary, multi-organizational team
- The opportunity to work together to create one, comprehensive Coordinated Care Plan by providing the infrastructure needed for successful coordination of care

Health Links as a Model of Care

Health Links encompasses all that is currently coordinated within the programs and services that are designed to care for the high user (complex) population in a given area, among an identified set of programs and providers, regardless of how individual programs and services currently define or measure that population.

"Integrated Collaborative Care"

Central East Health Links
Coordinated Care Planning Framework

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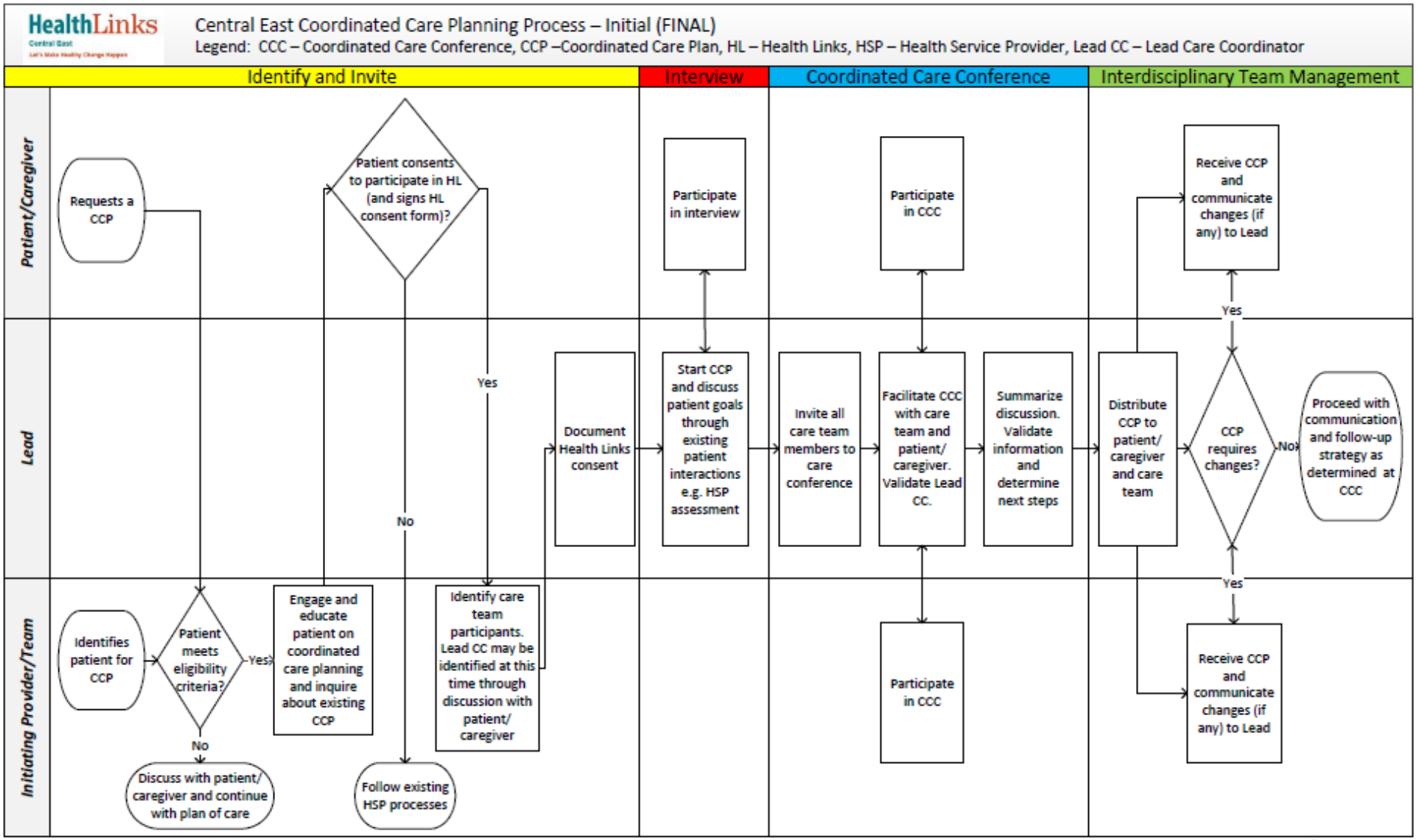
Legend
CCC = Coordinated Care Conference
CCP = Coordinated Care Plan

IDENTIFY AND INVITE	INTERVIEW	COORDINATED CARE CONFERENCE	INTERDISCIPLINARY TEAM MANAGEMENT
• Identify patient/ Patient self-identifies • Engage patient through discussions about coordinated care planning (including Coordinated Care Plan and Coordinated Care Conference) • Decide care team participants • Obtain consent	• Complete CCP demographics • Conduct patient interview/ explore patient's goals and needs	• Organize CCC • Invite care team • Conduct CCC • Determine action plan based on patient's expressed goals and needs • Determine Lead Care Coordinator • Determine communication and follow up strategy	• Lead Care Coordinator shares completed CCP and consent with care team/securely stores original copies • Proceed with actions and care as determined during CCC • Track/assess progress and update CCP as per the communication and follow up strategy

Central East Health Links Business Process Map



December 3, 2015

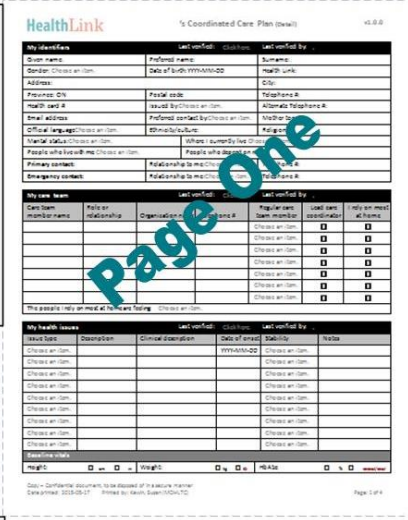
Who Should be Part of the Care Team?

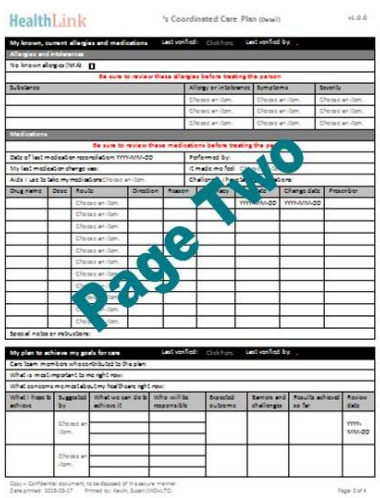
Any person/organization involved in the patients care, including:

- Patients
- Caregivers
- Primary Care Providers
- Medical Specialists
- Community Support Services
- Health Care Providers
- Home Care Services
- Family/Friends/Neighbours

Coordinated Care Plan

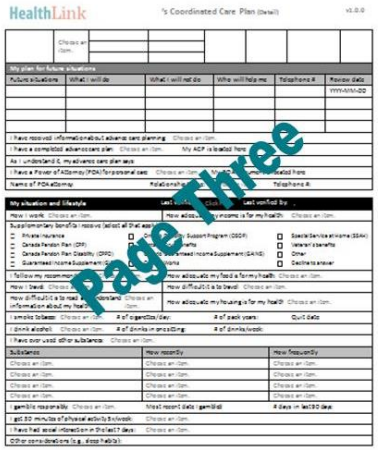
- My Identifiers
- My Care Team
- My Health Issues





- My Allergies and Medications
- My Plan to Achieve Goals for Care

- My Plan for Future Situations
- My Situation and Lifestyle



- My Assessments
- Hospital Visits
- Other Treatments
- Current Supports and Services
- Appointments and Referrals

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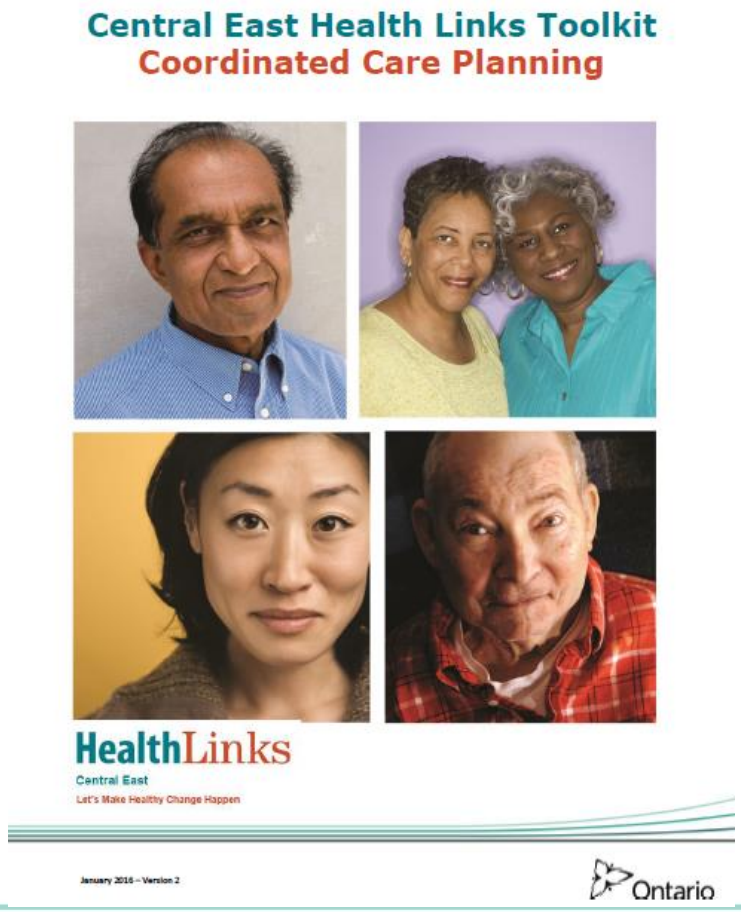
Central East Health Links Toolkit

- The Central East Health Links Toolkit is for any individual/ organization that will be participating in coordinated care planning.

- The Central East Health Links Toolkit describes the Coordinated Care Planning Framework and provides front line staff with the tools and resources available to support the creation and maintenance of Coordinated Care Plans with an inter-disciplinary Care Team which includes the patient/caregiver as equal partners in the patients care.

Where can I find the Toolkit?



Available for Download at:

http://healthcareathome.ca/centraleast/en/who/Documents/Health_Links/toolkit/CEHealthLinks-Toolkit-V2.pdf

Care Coordination Tool

- The Ministry of Health and Long-Term Care (MOHLTC) received approval to conduct a Care Coordination Tool (CCT) Proof of Concept (POC) Project that leverages the Integrated Assessment Record (IAR) for viewing of Coordinated Care Plans (CCPs).
- Orion Health (vendor), is supporting the MOHLTC and Health Links around the province by providing software and services needed to deliver CCT.
- The CCT Project leverages the Integrated Assessment Record (IAR) which is a provincially deployed solution that supports the viewing and sharing of assessment information as the client moves from one Health Care Provider to another

Care Coordination Tool Continued

- More efficient and effective care coordination across Health Care Providers within the Care Team through the provision of a **technology-enabled Coordinated Care Plan and secure messaging**
- Health Care Providers can create, store, and view patient's Coordinated Care Plans if they are within the patient's Care Team
- Patients can receive a copy of their Coordinated Care Plan from the CCT
- Those not using the CCT will still be included in the coordinated care planning process by receiving a paper version

Care Coordination Tool Continued

Two Central East Health Links were chosen to participate in the CCT Provincial Proof of Concept:

- Three network organizations in the **Peterborough Health Link** went "live" the week of **September 25, 2015** as part of Wave 1
- Lakeridge Health Corporation and Central East CCAC in the **Durham North East Health Link** went "live" the week of **November 17, 2015** as part of Wave 3
  - Since Go-Live, DMHS, CMHA, and Ontario Shores are now using CCT
- Future state: spread to additional Health Link partner organizations and increase CCT users

Participating in Coordinated Care Planning

As a member of the Care Team, you may be asked to:

- Complete sections of the Coordinated Care Plan
- Participate in a Coordinated Care Conference
- Work collaboratively with the patient and the Care Team to assist the patient in achieving the goals identified in the Coordinated Care Plan

Project Management Office

Name	Role	Central East Health Links	Contact Information
Craig Robinson	Senior Manager - Quality Improvement - LHIN Initiatives	All Central East Health Links (HL) Peterborough HL	Email: Craig.Robinson@ce.ccac-ont.ca Tel: 905-430-3308 x 5879 Cell: 905-621-8996
Carly Nolan-Bolton	Manager Assistant, Quality Improvement	All Central East Health Links (HL)	Email: Carly.NolanBolton@ce.ccac-ont.ca Tel: 905-430-3308 x 5871
Rachel Long	Central East LHIN Initiatives Communications Coordinator	All Central East Health Links (HL)	Email : Rachel.Long@ce.ccac-ont.ca Tel : 905-430-3308 x 5954 Cell : 289-685-2399
Maria Grant	Project Manager, Health Links	Scarborough North HL Scarborough South HL	Email: maria.grant@ce.ccac-ont.ca Tel: 905-430-3308 x 5854 Cell: 905-999-4603
Andrea Smith	Project Manager, Health Links	Northumberland County HL Haliburton County, City of Kawartha Lakes HL	Email: AndreaM.Smith@ce.ccac-ont.ca Tel: 905-430-3308 x 5912 Cell: 905-441-9441
Daniel Harren	Project Manager, Health Links	Durham North East HL Durham West HL	Email: Daniel.Harren@ce.ccac-ont.ca Tel: 905-430-3308 x 5973 Cell: 289-987-0636
Mandy Lee	Quality Improvement Facilitator, Health Links (QIF)	Northumberland HL Haliburton County, City of Kawartha Lakes HL	Email: Mandy.Lee@ce.ccac-ont.ca Tel: 905-430-3308 x 5888 Cell: 905-621-0524
Anum Rafiq	Quality Improvement Facilitator, Health Links (QIF)	Scarborough North HL Scarborough South HL	Email : Anum.Rafiq@ce.ccac-ont.ca Tel: 905-430-3308 x 5817 Cell: 905-626-4827
Lisa Gotell	Quality Improvement Facilitator, Health Links (QIF)	Peterborough HL Durham North East HL	Email: Lisa.Gotell@ce.ccac-ont.ca Tel: 905-430-3308 x 5928 Cell: 905-621-4035

For More Information

Central East Local Health Integration Network

www.centraleastlhin.on.ca

Ministry of Health and Long-Term Care

www.health.gov.on.ca

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