HealthLinks

Frequently Asked Questions for Providers

1) What is the Health Links approach?

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 care coordination, service delivery and integration activities that are central to the Health Links model are foundational to the *Patients First* strategy.

The Health Links approach to care provides an opportunity to strengthen linkages among care providers to support the delivery of primary care that is truly patient-centred. The optimal form of primary care is care that is comprehensive, that is based on a continuous patient-provider relationship, that coordinates services across the entire health system, and that ensures a high-level of access and equity in the delivery of services. The Health Links approach furthers this model by establishing relationships across the health system and by ensuring that services for patients with complex needs receive highly integrated and coordinated care.

2) What is Coordinated Care Planning?

The Health Links approach to coordinated care planning promotes a shared understanding of what is most important to the patient through the establishment of a Coordinated Care Plan, inclusive of clear roles and responsibilities for each member of the patient's Care Team.

Coordinated care planning (CCP) allows for more coordination and a streamlined approach as people transition from one provider to another, allowing people to live well in their community and reduce avoidable healthcare utilization.

3) Who is the target population 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
Important Considerations	• Frequent users of health services (e.g. emergency departments, hospital admissions) • Economic characteristics (e.g. low income, unemployment) • Social determinants (e.g. challenges with housing, social isolation, language) • Clinical judgment		

4) What are the benefits of the Health Links approach to care for patients?

Patient benefits include:

- *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.*

5) What are the benefits of the Health Links approach to care for providers?

Primary care provider benefits 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 and hospital admissions, as well as the utilization of other services that reduce continuity of care such as, walk-in clinics.*

Collaborating care team provider benefits include:

- *Providing a broader perspective and understanding about what the patient is experiencing*
- *Greater efficiencies and potential for partners to become specialized in their roles*
- *Understanding of roles and responsibilities of each member of the Care Team, leading to enhanced knowledge about what each provider is doing to support patient goals*
- *The opportunity to work in a team with a range of health and social service providers*
- *The opportunity to develop relationships with contacts both internal and external to primary care*
- *Greater alignment across Ontario through the implementation of standard processes, tools and communication materials that are recognized and followed by providers to support seamless patient care*

6) Who can initiate Coordinated Care Planning?

Anyone – a provider, friend, caregiver, the patient/client themselves. The Coordinated Care Planning process can be initiated while the patient is at home (including Retirement Home, Assisted Living, etc.) or in hospital. The Coordinated Care Plan can help support transitions from home to hospital and from hospital to home.

7) Who should be involved in Coordinated Care Planning?

The patient helps to decide; the Coordinated Care Planning Team (Care Team) is a group of professional and non-professional care providers, including the patient and caregiver, committed to working better together to support the patient in achieving their goals. A Care Team will include any individual, program or organization that the patient consents to contributing to and being involved in their Coordinated Care Plan.

Care team members could include the following:

- *Family, caregivers, supports*
- *Doctor/Nurse Practitioner/Nurse*
- *Specialist (e.g. Cardiologist)*
- *Allied Health Professional (e.g. social worker, dietitian, physiotherapist)*
- *Community Pharmacist*
- *Cultural/Community Supports (e.g. Traditional Healer, Translator)*
- *Someone from local Hospital (e.g. Nurse from emergency room, Navigator)*
- *Care Coordinator from Home and Community Care*
- *Someone from Mental Health and Addiction Services (e.g. Counsellor)*
- *Someone from Community Support Services (e.g. Homemaker Coordinator)*
- *Someone from Social Services (e.g. Ontario Works)*
- *Other Community Partners (e.g. French Mental Health & Addiction System Navigator, Spiritual Support)*

8) How does the Care Team differ from the 'Circle of Care?'

A Care Team participant is anyone the patient feels is involved in their care and does not have to be a designated Health Information Custodian.

Circle of Care is a term commonly used to describe the ability of certain health information custodians to assume an individual's implied consent to collect, use or disclose personal health information for the purpose of providing health care, in circumstances defined in PHIPA.

9) Who decides if Coordinated Care Planning will proceed?

The patient decides. While anyone from the list above may be asked to participate in the coordinated care planning process for a patient, not all need to be involved for the process to proceed. No single provider, not even the patient's primary care provider, has the authority to prevent coordinated care planning. As long as a couple of providers and the patient feels that the process would be valuable, coordinated care planning should proceed.

If a provider feels that s/he has the authority to prevent the coordinated care planning process, it would be reasonable for the Care Coordinator to explain that there are enough people, including the patient/client, who have deemed the process valuable enough for it to proceed. A copy of the

coordinated care plan should be shared with everyone who has been invited to participate in the coordinated care planning process, as determined with the patient, including: a) those who support the process but can't attend the conference and b) those who don't support the process.

10) What is the process for Coordinated Care Planning?

Once an individual is **identified,** and consent is obtained to participate in a CCP, one or two people from the Care Team (e.g. Home and Community Care - Care Coordinator and Counsellor) initially meet with the individual, face to face, to establish his/her care needs, any relevant social determinants of health, and care goals. Ideally, one of these Care Team members already has an existing, trusting relationship with the individual. This initial meeting also provides the opportunity to work together to identify existing care partners and anyone who should be included in creating a holistic care plan, including informal/cultural supports (e.g. Family, Spiritual support, Traditional Healer, Translator, etc.).

The Care Coordinator or an Administrative Support from the Care Team then coordinates a care conference with the team and individual present to develop the care plan, identify or confirm the Care Coordinator, and begin the journey toward better care. The Care Coordinator is considered the single point of contact for the care team and is responsible for regularly updating the team. Over time, care needs and goals may change; the care team will continue to monitor progress and adjust the care plan as required.

11) What is a Coordinated Care Planning conference like? Who is involved? Is the physician involved? Who leads the conference?

The Care Team typically meets with the patient/client/family face to face, in a setting that is most comfortable for the patient/client (e.g. their home, their primary care clinic). However, technology can be and has been leveraged to include people for whom face to face participation is difficult. For example, a specialist from an urban centre may join a conference in a rural setting via telephone or video conference. Additionally, for those patients/families who may find it difficult to leave home, they may participate with the assistance of someone from the care team via video conference technology.

It should be noted that the Care Team may meet amongst themselves prior to the patient joining the team for the conference.

The patient/client's primary care practitioner is typically part of the care team (described previously) and therefore, often present for the conference.

The discussion informs the creation of a Coordinated Care Plan, which is focused on how the care team can support the patient/client in reaching his/her goals. From a facilitation perspective, the Care Coordinator typically leads the conference. The Care Coordinator is typically someone with an existing, trusting relationship with the patient/client or someone who can easily develop a new relationship.

The Coordinated Care Plan is documented on a provincially standardized document and shared with the full Care Team.

12) What happens if the patient supports the Coordinated Care Planning process but does not want to participate in the conference?

Although this situation would be the exception, we have had a patient request that community, health and social service providers meet together without that individual present. As long as the initial meeting with the individual has been completed so that all Care Team members are able to focus the conference on how each of them will support his/her goals, the conference can proceed without the patient. In the spirit of patient-centredness, this approach should only be employed at the request of the patient.

13) What are the roles and responsibilities of the Coordinated Care Team?

All care team members involved in an individual's Coordinated Care Plan are responsible for:

- *Those actions agreed upon within the Coordinated Care Plan, including fulfilling their portion of system navigation for the patient*
- *Notifying the Care Coordinator of any requirements to update the Coordinated Care Plan*
- *Maintaining or improving communication amongst providers (both those within and external to their organization), regarding updates in status/planning for the individual*

The full coordinated care planning team shares in the effort to support the individual to meet his/her personal goals, as agreed upon in the coordinated care plan.

14) Can more than one person be the Care Coordinator?

Yes, the Lead model depends on the patient. In some cases, one provider may bring strengths related to experience with facilitating and documenting conferences. A second provider may already have an existing, trusting relationship with the patient and/or a deeper understanding of his/her needs. In situations like this, it is recommended that a 'partner leadership' model be adopted.

15) What is the difference between "Care Conferencing/Patient Rounds" vs. "Health Links approach to Coordinated Care Planning"?

Please see table below:

Type of Conferencing	Previous Approach to Care Conferencing/Patient Rounds	Health Links Approach to Coordinated Care Planning*
Multiple Providers contribute to plan/conference	**YES** Typically only healthcare providers	**YES** Typically, involves more people, including those beyond the healthcare sector
Patient consents to Process	**NO** Not required as long as discussion includes only providers considered within 'circle of care'	**YES** Patient involvement required to ensure that approach is patient-centred, considers the 'whole person', and includes people outside of the 'circle of care', as appropriate
Patient is consulted as to who participates in the Process	**NO** Participation is typically dictated by the location in which the patient is interacting with the system (e.g. hospital, community partners) and current providers engaged	**YES** Patient input is required to ensure a 'whole person' approach to wellness and to ensure that the right people are involved to support his/her goals
Conference and Care Planning is driven by Patient's Goals	**NO** In the past, providers have conferenced in order to set a plan for the patient	**YES** Coordinated Care Planning is patient-centred and heavily relies on all partners understanding and supporting the patient goals and wishes in order to build a plan with him/her
Conference/Plan is documented in each Provider's own format/system	**YES** Each provider typically documents his/her portion of the plan in his/her own system; the patient typically does not receive a copy	**NO** All Coordinated Care Plans are documented using the Provincial template; the Care Plan is shared with all partners, electronically or in hard copy, including the patient and non-healthcare partners
Patient is present and actively participating at the conference	**NO** In the past, providers have conferenced in order to set a plan for the patient	**YES** Patient is typically an active participant at the conference; in rare cases, the patient may decide that s/he wishes to not be present at the conference

**The Health Links approach to Coordinated Care Planning embraces the strengths of all multidisciplinary team approaches to overall wellness. It considers the "whole person" – viewing the balance mentally, physically, emotionally, and spiritually.*

16) When is a Coordinated Care Plan considered complete/closed?

A Coordinated Care Plan is a fluid document that adapts with the person, as their conditions / situation / goals change over time.

17) How is a patient's information protected?

When the Coordinated Care Planning Team encompasses the patient, family, and providers within the "circle of care", information and discussion occurs as with any other cross-sector collaboration/communication between providers. A patient consent process is leveraged when the care team includes people/organizations that would not be considered within this circle (e.g. Municipal Housing).

18) What ministries are involved in implementing the Health Links approach?

At the provincial level, the Ministry of Health and Long -Term Care has been directly involved in funding and supporting the Health Links approach across the province. However, at the patient level, organizations/people supported by other ministries are most certainly involved in coordinated care planning (e.g. Ministry of Municipal Affairs and Housing, Ministry of Community and Social Services).

19) How are determinants of health, such as housing, considered and addressed as part of the Health Links approach?

Patient goals lie at the heart of the Coordinated Care Planning process. If the determinants of health pose barriers/challenges to meeting those goals, the Care Team will work with the patient to best mitigate those challenges. The Care Team may be built/expanded, with support from the patient, to include members who might be most aware or can assist with access to resources such as social assistance, housing, or transportation.

20) How are primary care providers compensated for their involvement in the Coordinated Care Planning process?

Billing for common Health Links related activities may be found in the Schedule of Benefits.