

How will patients benefit from a Coordinated Care Plan?

The patient's experience 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.

How will coordinated care benefit providers?

- Collaborative care that effectively meets patient goals
- Improved patient safety by reducing risks and dissatisfaction associated with fragmented care
- Increased access to up-to-date information about your patient
- Communication and problem solving with an inter-disciplinary, multi-organizational team
- The opportunity to work together to create one, comprehensive Coordinated Care Plan
- Easier transitions to/from hospitals and other services
- Increased efficiencies in the health care system

HealthLinks

Central East

Let's Make Healthy Change Happen

For more information about the Central East Health Links please contact:

Phone:
905-430-3308 Ext. 5871

Toll-Free:
1-800-263-3877 Ext. 5871

Email:
ce.healthlinks@LHINs.on.ca

Web:
www.centraleastlhin.on.ca



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Let's Make Healthy Change Happen

Working Better
Together
to Coordinate Care
with Patients



What is a Health Link?

A **Health Link community** is comprised of the patients, family caregivers, providers, and broader system partners who reside or work within the Health Link geography who are committed to working better together to improve health outcomes for patients.

A **Health Link** is a local health care **network** consisting of patients, caregivers, health care providers and community support agencies that are committed to working better together to effectively identify every patient with complex health care needs and improve their health outcomes.

What does Health Links aim 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, eliminating unnecessary visits to the emergency department and repeat hospital readmissions through the initiation of a Health Links **Coordinated Care Plan**.

"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."

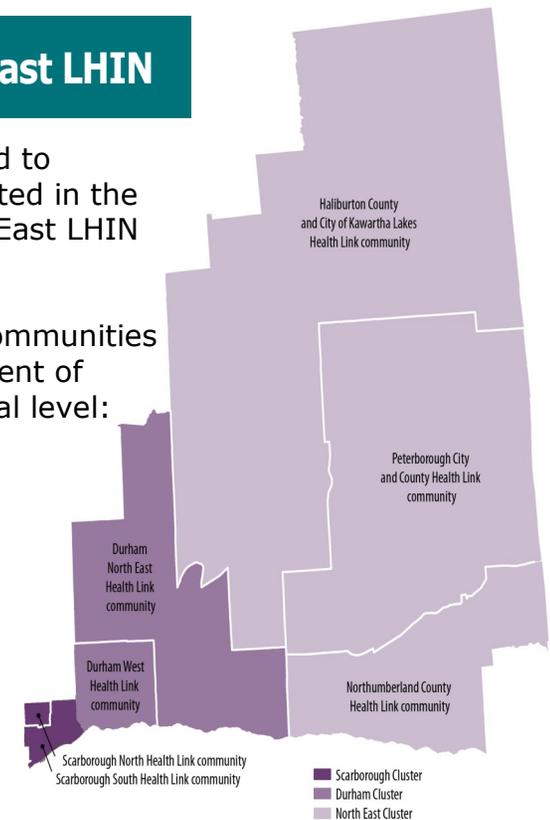
Patients First: Action Plan for Health Care
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Health Link sub-regions in the Central East LHIN

Local Health Link networks are perfectly positioned to implement the action steps and directions articulated in the *Patients First* action plan and achieve the Central East LHIN IHSP4 Strategic Aims.

In the Central East LHIN, the seven Health Link communities provide a geographic foundation for the development of local integrated systems of care at the sub-regional level:

- Scarborough North Health Link
- Scarborough South Health Link
- Durham North East Health Link
- Northumberland County Health Link
- Peterborough City and County Health Link
- Haliburton County and City of Kawartha Lakes Health Link
- Durham West Health Link



Identifying Patients for a Coordinated Care Plan

The Health Links target population focuses on Ontario's patients with complex care needs including:

- Vulnerable populations (a 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 social services etc.)

In addition, patients can be identified as complex and appropriate for a Coordinated Care Plan based on clinical judgement.