For Patients Living with Complex Chronic Conditions: Health Links Model of Care

Supporting patients can be difficult when multiple providers, appointments and complex issues are involved. Coordinated care management brings agencies and providers together to help patients meet their goals. The patient's care team determines agencies and actions that can best support the patient, documenting information on a coordinated care plan – a shared provincial template.

Coordinated care plans outlines the goals and actions driven by the patient who is fully involved in deciding the direction of their care. This model ensures the patient has a key role in their care planning, reduces the number of unnecessary hospital visits and promotes smoother transitions across the health care system.

Target Population

- People living with multiple chronic conditions
- Frequent users of emergency department

Identified Sub-Groups

- People living with mental health and addictions concerns
- People who are palliative or would benefit from a palliative approach
- People who are frail

Considerations

- Social determinants of health including concerns about income, unemployment, access to food, housing, transportation, social isolation, etc.
- Clinical judgement - unstable conditions, declining health, poor coping, etc.

Steps for Coordinated Care Management

Physicians who identify a patient can contact their care coordinator or submit a referral form.

1. **Identify** patient who would benefit from coordinated care management
2. **Invite** patient to participate and gain consent
3. **Engage** with patient to initiate care plan and build care team
4. **Share** information and conduct care conference
5. **Update** care plan and share as appropriate

The care team will determine which agency should take the lead role, based on their relationship with the patient. The lead agency can be from a variety of sectors and will work with the patient to build and expand the care team as goals evolve. Primary care will often be involved in the care team, and will receive a copy of their patient's care plan. For more information visit www.hnhblhin.on.ca