Integrated Care for Patients with Complex Health Conditions
Health Links Model of Care - Key Messages

Background

- The Integrated Care for Patients with Complex Health Conditions-Health Links Model of Care is a key commitment of the Ministry of Health and Long-Term Care and is based on coordinated care management.
- The ministry is standardizing the Model of Care, supporting its scale and spread to a mature state by March 31, 2020 →the focus in now on integrating coordinated care management within the delivery of programs and services instead of identifying it as a programmatic approach.

Provincial Vision

An approach to integrating care for patients living with complex conditions that optimizes sustainable and person-centred care, and serves as a model for sub-regions.

What is the Model of Care?

- The Model of Care helps individuals living with complex chronic conditions and/or complex needs reach their personal health goals by addressing health and social needs through coordinated care management.
- The Model of Care has health and social service providers working together to coordinate seamless care with patients and their families.
- Multiple providers, appointments and complex health issues can make it difficult to meet a patient's needs. Coordinated care management promotes a more effective approach to providing care and sharing information.

Key Goals of Coordinated Care Management Include:

- Improving coordinated care management for individuals living with complex chronic conditions and/or complex needs.
- Broadening the application of the coordinated care management to a wider population cohort that are aligned with sub-region activities.
- Embedding coordinated care management as part of the daily work in a more diverse group of service providers.
- Improving real time identification of patients who would benefit from coordinated care management.
- Developing strategies to identify risk factors that would indicate future need of coordinated care management to support early mitigation as a prevention method.
- Organizations collaborating to develop care plans (on Health Quality Ontario coordinated care plan template) that reflect patients' goals, level of acuity and need.
- Integrating coordinated care management into organization's programs, processes and pathways.
- Enhancing the ability to monitor and report the impact Health Links has on patient experience, quality and cost.

Who would benefit from coordinated care management model of care?

Patients with complex needs and/or multiple chronic conditions would benefit most from this model of care. The guidelines below can help support in identifying those patients who would benefit most from this model of care:

- Patients who need coordinated care management support from multiple community, health and social service providers.
- Patients whose high care needs are best supported by a team approach.

Target Populations	Patients living with complex needs and/or 4 or more chronic conditions		
Identified Sub-Groups	Patients living with mental health and/or addictions issues	Patients who are frail	Patients who would benefit from a palliative approach with a life-limiting progressive illness
Considerations	Clinical judgement: Unstable conditions/frequent exacerbations; indications of declining health; low health literacy and self-management skills, etc. Social determinants of health: Low income, unemployment, housing, transportation, food access, social isolation. High frequency utilization of health care resources i.e. Emergency Department visits, hospital admissions, Emergency Medical Services		

Model of Care Outcomes

- Empowered patients regain control of their own care.
- Improved patient outcomes through a clear plan to meet patient goals with defined roles and responsibilities for providers.
- Gaps in care are minimized and services are delivered in a more coordinated and seamless manner.
- Improved communication across sectors/organizations.
- Ability to see the right provider in the right place, at the right time.
- Emergency services used more appropriately.
- Improved system indicators (see below).

12-month Outcomes for Patients

	Number			Median		Statistical Significance (p-value < 0.05)
Indicator	12 Months Before Care Plan	12 Months After Care Plan	% Change	12 Months Before Care Plan	12 Months After Care Plan	
Emergency Department Visits	16,680	11,813	-29%	6	3	Yes
Hospital Admissions (Acute Care Hospital)	4,657	2,691	-42%	2	1	Yes
Days in Hospital (Acute Care Hospital)	40,269	26,707	-34%	11	2	Yes
Hospitalizations for ACSC (Ambulatory Care Sensitive Conditions)	647	456	-30%	-	-	Yes
ED Visits Best Managed Elsewhere	102	69	-32%	-	-	Yes
30 Day Readmissions	1,459	766	-47%	-	-	Yes

Data Source: Integrated Decision Support (July 2018). *Outcome Analysis for Individuals on Coordinated Care Plans 12 Months Post Coordinated Care Plan Date*.

*In 2018, Hamilton Niagara Haldimand Brant Local Health Integration Network conducted a quasi-experimental analysis that matched patients with coordinated care plans to patients with similar characteristics. Matched patients with a coordinated care plan had statistically fewer emergency department visits six months post-index date. Patients with a coordinated care plan demonstrated greater reductions in both inpatient admissions and emergency department visits 12 months post-index date[1].

[1] Bielska, I., Cimek, K., Guenter, D., O'Halloran, K., Nyitray, C., Hunter, L. and Wodchis, W. (2018). Change in health care use after coordinated care planning: a quasi-experimental study. CMAJ Open, 6(2), pp.E218-E226.