## *You are receiving this information sheet because a client or patient of yours has been identified as having complex health care needs that could be better met through coordinated care. As a result, a Health Link community partner may be contacting you to discuss the benefits of developing a coordinated care plan for your client and inviting you to participate in a case conference.*

***Coordinated care will help to reduce gaps in care that result from having many unconnected health care providers****.* ***Poor care coordination has been identified as a significant cause of adverse health outcomes and rising health care costs. As a health care provider, you play an important role in planning and organizing your client’s care.***

# What is Coordinated Care?

Patients/clients living with complex health issues require coordinated care to best manage their well-being.

The top 5% of patients consume about two-thirds of health care dollars, yet these clients with complex health conditions often receive the most poorly integrated care. Therefore, providers need to find ways to work together differently.

Coordinating care requires all health care providers involved in a client’s care to:

* Understand what is most important to the client and caregiver.
* Have timely and easy access to each client’s relevant health information.
* Participate in team discussions with patients/clients about how to best achieve their goals.
* Communicate on an ongoing basis to monitor and update the client’s care plan.

# What are Health Links?

Ontario is transforming care for people with complex conditions through Health Links. This innovative approach brings together health care providers in a community to improve coordinated care for high-needs clients.

# How Will Health Links Benefit Patients/Clients?

# http://healthydebate.ca/wordpress/wp-content/uploads/2013/02/crop_iStock_000006741261Small.jpg

Health Links will help patients with complex conditions have:

* An individualized care plan developed with the client and providers.
* A designated lead provider responsible for coordinating their care in partnership with the client and providers.
* Supported access to primary care.
* A circle of care who knows them and can help to reduce the number of times they have to tell their medical history.

# How Will Health Links Work?

# Providers in the Health Link put clients at the center of care. By bringing health care providers together as a team, providers will be able to connect clients more quickly to specialists, home care services and other community supports, including mental health services.

# How Coordinated Care Planning Works

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| 1. **A client is identified as having complex care issues that would benefit from coordinated care**

Client identification is based on clinical judgment – this may include clients with multiple care providers, frequent hospitalizations or complex social and health needs. 1. **The client is engaged to clarify their health care goals as well as to identify their care providers**

The focus is on the client’s goals and improving management of complex health issues. A provider who can play the lead Care Coordinator role may be identified at this point. A variety of providers may play this role. | 1. **The care team will meet to discuss how they can help the client with his/her health goals and challenges.**

The client can participate in this meeting, but is not obligated to do so. The lead Care Coordinator will put the agreed upon plan together and share it with the client and the team of providers. 1. **The lead Care Coordinator will work with the client and his/her care providers to improve the client’s health**

It is the lead Care Coordinator’s role to maintain the plan, ensuring the client and his/her health care providers continue to share information and keep the plan up-to-date. |

**Some Benefits of Coordinated Care:**

* Health care is focused on the client’s goals.
* The care plan includes input from the care team and client.
* The care plan is shared with the circle of care, including the client.
* The client, care giver, and providers all know who is responsible for which care plan goals.
* Everyone has the contact information needed to reach each care provider.
* There is a specific person responsible for supporting coordinated care for each individual client.
* Improved integration of care and smoother transitions between providers and institutions.