Engaging patients in coordinating care

Patients play an integral role in coordinating their care.

Three questions for patients to consider:
- What is most important right now?
- What is important in the near future?
- When is the right time to develop an Advance Care Plan for future care needs and care?

The patient’s role in coordinating care:
1. Communicating preferences and goals.
2. Clearly communicating care needs to the family physician and care team on an ongoing basis to help prevent unnecessarily worsening health.
3. Discussing how to best manage health conditions to give patients greater control over their care and health.
4. Knowing and understanding who is involved in the care plan and how to contact the providers.
5. Sharing the care plan with the team regularly to keep it up-to-date. The plan can be shared with other providers with new treatment recommendations.

What are Health Links?
Ontario is improving care for seniors and others with complex conditions through Health Links. This innovative approach brings together health care providers in a community to better and more quickly coordinate care for high-needs patients.

How will Health Links benefit patients?
Health Links will help patients with complex conditions have:
- A care provider they can call, helping eliminate unnecessary provider visits.
- An individualized care plan developed with the patient and providers.
- Assistance to help them take the correct medications appropriately.
- A circle of care who know them and 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 patients at the centre of care. By bringing health care providers together as a team, family doctors will be able to connect patients more quickly to specialists, home care services and other community supports, including mental health services. Health Link providers will also help with follow-up and referral to services like home care, helping reduce the likelihood of re-admission to hospital.

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For Family Physicians
Why is coordinated care important?

Patients require coordinated care to best manage their conditions. The top 5% of patients consume about two-thirds of health care dollars. As the population ages and the prevalence of chronic diseases increases, the way care is delivered currently will not be sustainable. Therefore, providers need to find ways to work together differently.

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

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

How to get started

1. Getting Connected to a Care Coordinator
   The Toronto Central CCAC is working to assign a care coordinator to help physicians monitor and plan care for their complex patients. This is complementary to the work of the Health Link. You can contact the Community Care Access Centre (contact number: 416-310-2222). A CCAC care coordinator may not be required if the patient has someone already involved in their care who can fulfill this role.

Invite your patient to participate
   You or a care coordinator can invite a patient to participate by providing information about the importance of planning their care. A brochure for patients is available at sunnybrook.ca/ccp-toolkit

2. A Care Plan Template is available at sunnybrook.ca/ccp-toolkit
   The purpose of the template is to have concise information about the patient’s needs. It should be discussed with the patient and health providers involved in the patient’s care. A CCAC Care Coordinator or any member of the care team, including the patient and family, can complete sections of this template.

3. Schedule a visit with your patient and Care Coordinator.
   At the visit:
   a. Review what is most important to the patient/family.
   b. Review the patient’s goals of care.
   c. Discuss the patient’s current and anticipated health conditions.
   d. Identify preferred strategies to achieve goals and reduce health risks.

   Care planning may require more than one visit.

4. The Care Coordinator will then:
   e. Review the completed Coordinated Care Plan Template with the patient to confirm accuracy.
   f. Make any revisions as appropriate.
   g. Share a copy of the completed CCP with the patient and the circle of care.
   h. Instruct the patient to bring the completed CCP to all health care visits, including the Emergency Department and specialists.

A summary of services provided by Community Care Access Centres and how to access these services can be found at: http://healthcareathome.ca/torontocentral/en/Partners/Health-care-Providers/Physicians