HealthLink

Muskoka Community

Let's Make Healthy Change Happen

Muskoka Health Link Frequently Asked Questions

Q1. What is Muskoka Health Link?

A1. Muskoka Health Link is a team of providers in Muskoka (primary care, hospital, home care, community care, long-term care providers, community support agencies, and other community partners) working together to provide coordinated health care to Clients with multiple complex conditions – often seniors – with the Client at the center. Providers design a care plan for each Client and work together with Clients and their families to ensure they receive the care they need.

Q2. What are the Guiding Principles of Muskoka Health Link?

A2. The Ministry of Health and Long Term Care (MOHLTC) provided the following for Health Link Guiding Principles:

1. Regular and timely access to primary care for complex Clients;
2. Effective provision of coordinated care for all of Ontario's complex Clients;
3. Consistent, quality care across the health care continuum and social services sectors;
4. Focus on vulnerable populations (frail and elderly, mental health and addictions, and palliative);
5. Evidence-based, measureable improvement of the Client experience through enhanced transitions in care;
6. Maximize coordinated care to generate system value, sustain the Health Link Model, and strengthen care coordination processes to realize greater efficiencies;
7. North Simcoe Muskoka Local Health Integration Network (NSM LHIN) has accountability for performance. NSM LHIN provides oversight of Muskoka Health Link and is accountable to the MOHLTC for Muskoka Health Link's performance; and
8. Shared MOHLTC, NSM LHIN, and Muskoka Health Link's accountability for overall success.

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Q3. What is Muskoka Health Link doing for Muskoka?

A3. Our key goal is to strengthen linkages between primary care and the broader system of health and social services.

- Rural communities have easier access to primary care in Muskoka through the Muskoka Community Health Hubs in Dorset, Port Carling, Wahta, and the Mobile Unit which provides services to Vankoughnet, Port Sydney, and Severn Bridge.
- Developing coordinated care plans for clients with complex or chronic health and social needs.

Q4. Who can receive coordinated care planning through Muskoka Health Link?

A4. Any individual who is:

1. Living with complex conditions and is a high user of the health system, or is at risk of becoming a high user of the health system in one or more of the following ways:
    - Individual hospitalized in the last 3 months
    - 1 or more visits to the emergency department in the last month
    - Greater than 3 contacts with primary care provider in the last month
    - Greater than 3 organizations providing care to this individual

AND

2. Currently dealing with 4 or more of the following criteria:

- Lives Alone
- Identified Disability (e.g. physical, visual, hearing, other)
- Failure to Cope at Home
- Low Income / Ontario Works / ODSP
- Frail
- Multiple Medications (5+)
- Addiction Issue(s) (e.g. alcohol, smoking, drugs, gambling, other)
- End of Life / Palliative
- Cognitive Impairment / Dementia
- Risk of Falling
- Caregiver Burnout
- Chronic Disease(s) (e.g. diabetes, CHF, COPD, cancer, other)
- Poor Nutrition
- Mental Health Issues (e.g. depression, bipolar, PTSD, schizophrenia, other)
- Other

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Q5. How can you become a Muskoka Health Link Client?

A5. Ask how you can be connected to Muskoka Health Link by speaking to your primary care provider or social services provider. More information can be found on our website at muskokahealthlink.ca.

Q6. Who can refer clients to Muskoka Health Link?

A6. Any health care provider or social services provider, including:

- Primary care providers (i.e. physicians, nurse practitioners, etc.)
- Family health teams
- Social service agencies
- North Simcoe Muskoka Community Care Access Centre
- Canadian Mental Health Association Muskoka Parry Sound
- Muskoka Algonquin Healthcare (Hospitals in Bracebridge and Huntsville)
- Muskoka Paramedic Services
- Ontario Provincial Police
- Fire Fighters
- Hospice
- Schools
- Other

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Q7. What is the Muskoka Health Link Referral Process?

A7. Muskoka Health Link has attempted to make the referral process as efficient as possible.

1. Identify and refer clients who meet the criteria as outlined on the Muskoka Health Link Eligibility Form (as indicated in Question 4 above).
    a. Obtain Client consent and have the Client sign the Muskoka Health Link Participant Consent Form;
    b. Complete the Muskoka Health Link Eligibility Form; and
    c. Securely fax the completed Eligibility Form and signed Participant Consent Form to 705-645-9358.

2. A Health Link Care Navigator will be assigned to work with the Care Team to assist and support the Client's needs:
    a. Muskoka Health Link Needs Assessment Tool may be used to identify Client goals;
    b. A Coordinated Care Plan will be completed for the Client; and
    c. Scheduling a Coordinated Care Conference, if required.

Q8. What is a Coordinated Care Plan?

A8. A Coordinated Care Plan is:

- A document that summarizes the Muskoka Health Link Client's needs, goals, barriers, identifies Care Team members, and shows a plan to meet the Client's goals, including advanced care plans;
- Shared with all Care Team members; and
- Anticipated to be updated based on the progress of the Client.

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Q9. Who are the Muskoka Health Link System Navigators and the Muskoka Health Link Care Navigators?

A9. System Navigators are health care or social services providers who are the most appropriate primary contact to support the Muskoka Health Link Client. System Navigators may be primary care providers, social workers, case managers, patient experience flow navigators, or care coordinators.

Care Navigators may act as System Navigators, or may act in a supportive capacity to the System Navigators. Care Navigators also work together to improve efficiencies to the Muskoka Health Link process so that Clients receive the best care possible.

Q10. What do System Navigators and Care Navigators do?

A10. System Navigators and/or Care Navigators:

- Are responsible for collaborating with Muskoka Health Link partners to identify and link Health Link Clients with health, social, and community services and programs;
- Aid in the facilitation and development of the coordinated care plans with care partners and providers, organizes and facilitates coordinated care conferences, monitors Clients' needs, conducts surveys, and evaluates outcomes;
- Arranges, coordinates, and ensures the effectiveness of the services being provided to Clients with multiple medical and/or socially complex needs;
- Communicates with Clients to explain the Muskoka Health Link approach to care, schedule meetings and coordinated care conferences, completes assessments / reviews, and maintains regular contact with Clients and care partners; and
- Facilitates communication and collaboration with members of the Care Team, the Client, and their caregivers in order to optimize outcomes and to ensure the Client's goals are met.

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Q11. What is a Coordinated Care Conference?

A11. The purpose of the Coordinated Care Conference is to bring together the Care Team to share information and to collaboratively create an action plan for meeting the Client's expressed goals and needs.

The Coordinated Care Plan will be finalized at the Coordinated Care Conference and will be shared with the Care Team along with the signed consent. When possible, the Client should be present at the Coordinated Care Conference. If they are not able to attend or choose not to attend, efforts should be made to ensure that a caregiver is present and that the Client's goals are understood and clearly recorded in the Coordinated Care Plan as a result of the Client interview.

Q12. What is the role of the Coordinated Care Conference?

A12. The role of a Coordinated Care Conference is to:

1. Review, confirm, or revise a Client's Coordinated Care Plan (CCP), including goals;
2. Identify any gaps in programs, supports, and services required to implement the CCP;
3. Problem solve for better coordination of services to address any gaps in programs, supports, or services;
4. Clarify roles of each team member, including the client and family / caregiver;
5. Identify any other service providers who should be added to the Care Team going forward; and
6. Assign or re-assess the most appropriate provider to serve as System Navigator, or Care Navigator.

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