South-East Ottawa Community Health Centre
Every One Matters.

Centre de santé communautaire du sud-est d'Ottawa
Chaque personne compte.

Regional Integrated Care
Frequently Asked Questions: Clients and Families

1. What is Integrated Care?

Integrated Care (formerly referred to as the 'Health Links' approach) is about bringing a person's health care, social service providers and other supports together to better understand their goals and support them in a more coordinated way.

A Coordinated Care Plan will help clients with multiple health problems and their Care Teams better manage their health and well-being, and the Care Team will work with clients and their families to help them meet their goals.

Coordinated care planning is meant to support a client's overall wellness. It considers his or her "whole person" needs – mentally, physically, emotionally, and spiritually. Clients are asked to think about cultural or community support people that they would want included on their Care Team to help support this "whole person" approach (e.g. spiritual support, traditional healer, naturopath, neighbour, friends, etc.)

2. What is Coordinated Care Planning?

Coordinated care planning promotes a shared understanding of what is most important to the client through the establishment of a Coordinated Care Plan, which includes clear roles and responsibilities for each member of the client's Care Team.

Coordinated care planning (CCP) allows for more coordination and a streamlined approach as people transition from one provider to another, allowing people to live well in their community.

3. What are the benefits of integrated care for clients?

Benefits of integrate care include: care being focused on the client's goals, providers having a consistent understanding of their clients' conditions, easier navigation of health care services, clients feeling more supported in their health care journey, having fewer visits to hospitals, and focusing on improved quality of life.

4. Who can initiate Coordinated Care Planning?

Anyone – a provider, friend, caregiver, the patient themselves. The Coordinated Care Planning process can be initiated while the client is at home (including Long Term Care, Retirement Home, Assisted Living, etc.) or in hospital. The Coordinated Care Plan can help support transitions from home to hospital and from hospital to home.

5. Who should be involved in Coordinated Care Planning?

The client helps to decide; the Coordinated Care Planning Team (Care Team) can be a group of professionals and non-professionals, including the client and caregiver, committed to working better together to support the client in achieving their goals. A Care Team will include any individual, program or organization that the client consents to contributing to and being involved

in their Coordinated Care Plan.

Care team members could include the following:

- Family, caregivers, supports
- Doctor/Nurse Practitioner
- Nurse
- Specialist (e.g. Cardiologist)
- Allied Health Professional (e.g. social worker, dietitian, physiotherapist)
- Community Pharmacist
- Cultural/Community Supports (e.g. Traditional Healer, Translator)
- Someone from local Hospital (e.g. Nurse from emergency room, Navigator)
- Care Coordinator from Home and Community Care
- Someone from Mental Health and Addiction Services (e.g. Counsellor)
- Someone from Community Support Services (e.g. Homemaker Coordinator
- Someone from Social Services (e.g. Ontario Works)
- Other Community Partners (e.g. French Mental Health & Addiction System Navigator, Spiritual Support)

6. Who decides if Coordinated Care Planning will proceed?

If they are eligible, the client decides. While anyone from the list above may be asked to participate in the coordinated care planning process for a client, not all need to be involved for the process to proceed.

A copy of the coordinated care plan should be shared with everyone who has been invited to participate in the coordinated care planning process, as determined with the client.

7. How is a client's personal health information protected?

Written consent is obtained from the client when the care team includes people/organizations that would not be considered within their immediate "circle of care" (e.g. Community Housing).