**IMPLEMENTATION OF HEALTH LINKS COORDINATED CARE PLANS FOR ADULTS WITH INTELECTUAL AND DEVELOPMENTAL DISABILITIES: A CROSS-SECTORAL COLLABORATION**

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**Objectives:** Health Links is an Ontario initiative that brings together local healthcare providers to provide patient-centered, enhanced care coordination and system navigation for the most complex patients. People with intellectual/developmental disabilities (IDD) have been identified as a complex population that would benefit from Health Link system coordination as they experience higher rates of emergency department use, higher rates of hospitalizations due to ambulatory care sensitive conditions, and have poorer health status and access to health care compared to the general population. The tool used by Health Links is the Coordinated Care Plan (CCP), which helps patients and their caregivers identify goals, document health information and develop a coordinated plan that is tailored to fit the patient’s unique needs for health and social support. This study examines the implementation of the Health Links approach to care coordination for adults with IDD and complex health needs in Kingston, Ontario, and explores the experience of participants relating to the clinical and social outcomes of patient participants.

**Methods:** A review of the implementation process with researchers is underway to refine referral processes as well as to identify facilitators and barriers to program implementation. An analysis of CCPs and patient charts at the Health Link and local hospitals has been undertaken to describe patient characteristics and service usage. Semi-structured interviews 6-12 months post-implementation will also be conducted with patients, family caregivers and healthcare providers exploring their experience in the Health Links program. Thematic analysis of the transcripts will be preformed, with themes verified by two separate researchers.

**Results:** Data collection is in progress. A total of 15 individuals were referred to the project from either health or social service sectors. To date, 9 of these individuals have consented to having a CCP developed. Barriers to the implementation of CCP tools in our region included delays in recruitment, determining how to navigate and define roles between two Ministries and a lack of understanding about Health Links in general. Facilitators included having the expertise of an experienced Care Coordinator and a central location to house electronic medical records for study participants. Profiles of those for whom CCPs were completed were consistent with the aim of intervention to support medically complex individuals, with preliminary results indicating a range of 5-11 physical health issues per patient. Common concerns identified on CCPs and addressed by the Care Coordinator included financial stress, uncertainty around advanced care planning and caregiver burnout. A summary of experience taking part in the implementation will also be presented from the perspective of patient, caregiver and health/social care providers.

**Discussion/Conclusion:** The goal of the intervention is to deliver coordinated, patient-centered care to vulnerable and complex patients in our region. Although the pilot experienced delays and barriers to implementation, preliminary results indicate that concrete interventions were introduced to address medical and social concerns experienced by participants. This pilot can be used to inform the expansion of Health Links coordination interventions that target other vulnerable populations across Ontario.

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