Coordinated Care Plan Toolkit

DRAFT March 2014
Prepared by:
Jocelyn Charles, Co-chair, NETHL Advisory Council
Acknowledgments

This should acknowledge that this work was led by Dr. Jocelyn Charles at the North East Toronto Health Link in collaboration with:

1. **North East Toronto Health Link Patient Advisory Council**: Co-designed content and language of Coordinated Care Plan Summary Template for Complex Adults.

2. **Toronto Central LHIN Consultative Retreat May 9th, 2013**:

   Objectives of Retreat:
   - Understand the Diverse Care Needs of Complex Patients
   - Create a DRAFT Shared Vision of a CCP Toolkit
   - Begin to Identify Inclusion Criteria for Toolkit
   - Establish a Smaller Working Group to Develop a Pilot Toolkit

   **Participants**:
   - Dr. Reva Adler, Bridgepoint Hospital
   - Jenn Bottoms, Sunnybrook Health Sciences Centre
   - Dr. Edward Brown, Ontario Telemedicine Network
   - Julie Colegate, Toronto Central Community Care
   - Dr. Betty Choi-Fung, Scarborough Family Health Team
   - Einat Danieli, The Cyril & Dorothy, Joel & Jill Reitman Centre for Alzheimer’s Support & Training
   - Shez Daya, Toronto Central Local Health Integration Network (LHIN)
   - Mira Dodig, Flemingdon Health Centre
   - Dr. Karen Fleming, Sunnybrook Health Sciences Centre
   - Anne Finlay, Telehomecare
   - Martha Greenberg, Ministry of Health and Long Term Care
   - Jodeme Goldhar, Toronto Central Community Care Access Centre
   - Dr. Michelle Grinman, Toronto East General Hospital
   - John Klich, Toronto Emergency Medical Services
   - David Lamb, Ministry of Health and Long Term Care
   - Dr. Jacques Lee, Sunnybrook Health Sciences Centre
   - Robert Lee, Toronto East General Hospital
   - Beth Linkewich, North & East GTA Stroke Network
   - Sheena Luck, Anne Johnston Health Station
   - Dr. Michael Matthews, Sunnybrook Health Sciences Centre
   - Tory Merritt, Health Links
   - Malcolm Moffat, Sunnybrook Health Sciences Centre
   - Anne Moorehouse, Sunnybrook Health Sciences Centre
3. **Coordinated Care Plan Toolkit Working Group:** Reviewed content requirements for providers engaged in coordinated care plan.

**Participants:**
- Aleem Bhanji, Toronto Central Community Care Access Centre
- Dr. Betty Choi-Fung, Scarborough Family Health Team
- Einat Danieli, The Cyril & Dorothy, Joel & Jill Reitman Centre for Alzheimer’s Support & Training
- Shez Daya, Toronto Central Local Health Integration Network (LHIN)
- Mira Dodig, Flemingdon Health Centre
- Dr. Karen Fleming, Sunnybrook Health Sciences Centre
- Robert Lee, Toronto East General Hospital
- Sheena Luck, Anne Johnston Health Station
- Anne Moorehouse, Sunnybrook Health Sciences Centre
- Dr. Mireille Norris, Sunnybrook Health Sciences Centre
- Cheryl O’Connor, Community Psychiatry Services for the Elderly
- Laurie Poole, Ontario Telemedicine Network
- Lisa Priest, North East Toronto Health Link
- Mary Rosemin, Ontario Telemedicine Network
- Tanuka Roy, Senior Peoples’ Resources in North Toronto (SPRINT)
- Gayle Seddon, Toronto Central Community Care Access Centre

4. **Experienced-Based Coordinated Care Planning Sub-Group:** Refined Coordinated Care Plan Summary Template based on coordinated care planning initiatives, ICCP and IMPACT-Plus.
Participants:
Aleem Bhanji, Toronto Central Community Care Access Centre
Jodeme Goldhar, Toronto Central Community Care Access Centre
Seonag MacRae, Woodgreen Community Services
Dr. Pauline Pariser, Taddle Creek Family Health Team, Mid-West Toronto Health Link Network
Dr. Tia Pham, South East Toronto Family Health Team

5. IDEAS Cohort 2 Participation February – June 2014: Identifying the core elements and processes for coordinated care planning for high users.

Participants:
Dr. Jocelyn Charles, Sunnybrook Health Sciences Centre
Anne Moorehouse, Sunnybrook Health Sciences Centre
Dr. Ajibike Oyewumi, Health Quality Ontario
Gayle Seddon, Toronto Central Community Care Access Centre

6. East Toronto Health Link Advance Care Planning Toolkit – Provided the advance care planning materials for the Coordinated Care Plan Toolkit template summary.

Participants:
Doreen Ouellet, East Toronto Health Link, Advance Care Planning Lead Coordinator

7. Consultation from Bob Parke, Clinical Ethicist, Humber River Regional Hospital and Blair Henry, Ethicist, Sunnybrook Health Sciences Centre in providing assistance with anticipatory care planning questions.
TC LHIN Coordinated Care Plan Toolkit

Introduction:

Coordinating care for complex patients with diverse care needs by multiple providers in a wide range of health care environments is in and of itself a complex task. In order to achieve consistency and ensure that each patient benefits from evidence-informed, patient-centred care, goal setting and planning of care delivery strategies, a common and shared toolkit is under development in the TC-LHIN.

Given the level of complexity involved in care planning for complex patients, it is important to identify the minimum specifications,(1) or the “minimum set of rules to shape action,” in order to give direction to achieve coherence. Coherence is important as it will allow the achievement of required care standards, evidence-informed practices as well as a common understanding of expectations while allowing for flexibility in care planning and delivery to meet diverse patient/caregiver needs.

These minimum specifications for coordinated care plans include(2):

- **Easy access** to shared care plans by each patient and his/her circle of care
- **Effective assessments** to guide care goal-setting and planning
- **Prevention** & education strategies to avoid crises
- **Continuous information flow** so that the patient, caregiver and entire circle of care are continuously informed of all changes
- **Continuous feedback** with evaluation and feedback loops and responsive changes

Purpose of a Coordinated Care Plan:

To facilitate optimal understanding and management of chronic and/or complex health conditions by patients, their families, and their health care providers working in collaboration and supported by clear communication and system navigation.

Vision for Coordinated Care Plan:

A “live real-time” Interactive EMR-Interfaced Coordinated Care Plan which will be:

- Located in patient’s “medical home”
- Access to view by patient, designated family members and entire circle of care
• Sections updatable by relevant providers, for example:
  • Patient can update social history, goals of care, advanced care planning
  • Pharmacist can update medication list
  • Community care providers can update services
  • Includes functional status, risks, anticipatory plans
• Person-centred & goal-directed
• Flexible & responsive to change
• Promotes self-management
• Built on existing resources & strategies
• Clear expectations, accountabilities
• Supported by technology-enabled communication & navigation systems

Coordinated Care Plan Requirements: The “7 A’s”

Advised by patients through co-design
Accessible by patients/caregivers and circle of care
Available 24/7
Adjustable by patient or any member of circle of care
Alerts to circle of care with changes in health/care
Accurate – always up-to-date and evidence informed
Anticipatory – advanced planning of possible decline

Key Components:
The Care Plan will be based on evidence-informed, standard assessment protocols with collaboratively identified goals of care. Care interventions will be congruent with the care goals and screened for interactions between different disease guidelines to ensure optimal for patient’s co-morbidities. Appropriate monitoring and communication will be prompted based on the care goals and interventions developed. Prevention strategies will be embedded in the care plan and specific tools will be prompted to ensure safe transitions. These are under development.
CO-ORDINATED CARE PLAN TEMPLATE: Guide for Completion

Introduction:

The purpose of the Coordinated Care Plan (CCP) Template is to have a standardized and concise reference guide about what is important to know about a patient if you are in the circle of care or joining the circle of care. It is intended for use by patients, their families, and their care providers to promote a common understanding of the patient’s health-related conditions, goals of care, and preferred strategies to achieve identified goals. The CCP should be accessible and kept up-to-date by the patient and circle of care.

Guiding Principles:

1. The Care Plan Template is intended for use in all adult populations with complex health needs.
2. Any member of the circle of care can complete or contribute to completing the care plan, including the patient and/or any person authorized by the patient.
3. The circle of care providers include health care providers and any person identified by the patient as important to their health and care.
4. Health conditions include current conditions that are having an impact on the person’s health status and may include:
   a. Determinants of health (e.g. housing, income, social & physical environment, safety, health literacy)
   b. Medical diagnoses
   c. Mental health conditions
   d. Substance use
5. Safety Net and Care Goals are based on patient-centred dialogue which is informed by the circle of care.
6. Action Plan can include any actions by any member of the circle of care that are related to achieving the person’s goals of care. Accountability for these actions is also specified.
7. The Advance Plan will be informed by the ETHEL Health Link working group and is subject to change in the near future.

Feedback:
The current Coordinated Care Plan Template was created through patient and provider co-design. Feedback for future revision based on experience with coordinated care planning efforts is welcome and encouraged. Please forward your comments by email to Jennifer Agyei at jennifer.agyei@sunnybrook.ca.
GOAL:
Decrease acute care utilization by complex patients (as defined by ICCP) by 20% by March 31, 2017, through improving coordination of care.

SYSTEM:
- Patient-Centred
- Integration
- Efficiency
- (safety)

SYSTEM INTEGRATION

1º DRIVERS

- Common Vision
- Common Health Record
- Common Care Plan with Goals
- Alignment of Incentives
- Access to Information
- 2-Way Communication System with Ability to Ask Questions/Clarify
- Patient Engagement Through-out Care Processes / Transitions
- System Role Clarity

- CCP Summary Template TOOL
- Patient Identification & Enrollment
- Care Planning Process
- Care Coordination Communication Methods
- Care Planning
- Effective Models of Inter-Organizational Integrated Care
### Common Care Plan with Goals

#### AIM STATEMENT:
25% of identified complex patients at SBAFHT & AJHS will have identified patient goals with aligned interventions and providers that is able to respond to changes in health status by June 15, 2014

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<td>CCP Summary Template</td>
<td>Method to Continuously Identify Patient</td>
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<td>Core Elements of Care Planning Process</td>
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<td>Establishment of Process for Ongoing Management of Care Plan</td>
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<td>Key Standards for when how, who and what</td>
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<td>Dissemination &amp; Education of Framework</td>
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<td>Effective Models of Inter-Organizational Integrated Care</td>
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<td>Define Accountability Framework for Communication within Circle</td>
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<td>Define Principles of Integrated Care for Different Complex Populations</td>
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References


2. The Great Missenden Group (work group on the elderly people's integrated care system (EPICS), November 1998

3. Toronto Central CCAC Integrated Client Care Program

4. Sunnybrook Department of Family & Community Medicine IMPACT-Plus Model

5. East Toronto Health Link Advance Care Planning Toolkit – Doreen Ouellet, Advance Care Planning Lead Coordinator