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# What is the Health Links approach?

The Health Links approach intends to improve communication and collaboration among all who share in the care of people with high care needs. Multiple providers, appointments and complex care issues can make it difficult to meet these individuals’ needs. A more collaborative approach to providing care can be achieved through a process called “Coordinated Care Planning.”

# What is Coordinated Care Planning?

Coordinated care planning brings together multiple providers, the patient/client, and his or her informal supports to enable the development of a care plan that best supports the patient/client hopes, goals and needs. To ensure a standardized, high quality approach for all, the Care Plan is documented on a provincial template which can be shared and viewed across the healthcare system. This shared Care Plan allows for more coordination and a streamlined approach as people transition from one provider to another, enabling people to live well in their community and reduce avoidable healthcare visits.

# Who is the target population for Coordinated Care Planning?

There is no set eligibility for Coordinated Care Planning but providers should think about **people who would benefit most from coordinated support** from multiple community, health and social service providers and those with **high care needs** who would be best supported with a team approach, as outlined by the following table.

|  |  |  |  |
| --- | --- | --- | --- |
| **Target Population** | People living with **4 or more chronic and/or high cost conditions** | | |
| **Identified Sub-Groups** | People with **Mental Health and/or Addictions** Challenges | **People with Palliative Care Needs** | **Seniors who are frail** |
| **Considerations** | Consider the following:   * Economic characteristics (e.g. low income, unemployment) * Social determinants (e.g. challenges with housing, social isolation, language barriers) * **5+ Emergency Department** (ED) visits in the past year * **4+ ED Visits** AND **3+ Hospital Admissions** in the past year | | |

# Who can initiate Coordinated Care Planning?

Anyone – a healthcare or service provider, friend, caregiver, the patient/client themselves. The Coordinated Care Planning process can be initiated while the patient/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.

# Who should be involved in Coordinated Care Planning?

The **individual helps to decide who is part of his or her Care Team**. The Care Team could include the following:

* + Family, caregivers, supports
  + Doctor/Nurse Practitioner
  + Nurse
  + Specialist (e.g. Cardiologist)
  + Health Professional (e.g. social worker, dietitian, physiotherapist)
  + Community Pharmacist
  + Someone from local Hospital (e.g. Nurse from emergency room, Navigator)
  + Care Coordinator from LHIN Home and Community Care
  + Someone from Mental Health and Addiction Services (e.g. Counsellor)
  + Someone from Community Support Services (e.g. Service Planner)
  + Someone from Social Services (e.g. Housing)
  + Other Community Partners (e.g. Lifelong Care Worker)
  + Someone who provides spiritual/cultural/language support (e.g. Elder, translator)

# Who decides if Coordinated Care Planning will proceed?

The patient/client. Although anyone may be asked to participate in the Coordinated Care Planning process for a patient/client, not all need to be involved for the process to proceed. No single provider, not even the patient/client’s primary care provider, has the authority to prevent Coordinated Care Planning. As long as a couple of providers and the patient/client feel that the process would be valuable, Coordinated Care Planning should proceed.

If a provider feels that s/he has the authority to prevent the Coordinated Care Planning process, it would be reasonable for the Lead to explain that there are enough people, including the patient/client, who have deemed the process valuable enough for it 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 patient/client, including: a) those who support the process but can’t attend the conference (e.g. Primary Care Provider who was unable to attend initial conference) and b) those who don’t support the process (e.g. an informal or formal support who did not think that Coordinated Care Planning should proceed).

# What is the process for Coordinated Care Planning?

Once an individual is **identified** and consent is obtained to participate in Coordinated Care Planning, a Lead is determined. The Lead is ideally someone with an existing, trusting relationship with the patient/client and becomes the single point of contact for the care team. The Lead and the patient/client meet face to face to establish the individual’s hopes, needs and goals. They work together to identify existing care partners and anyone who should be included in creating a care plan, including informal supports (e.g. family, spiritual support). The Lead coordinates and facilitates a **care conference** with the Care Team and patient/client present to develop the Care Plan and begin the journey toward more coordinated, integrated care. Over time, care needs and goals may change; the Care Team will continue to **monitor progress** and adjust the Care Plan, as needed.

# What is a Coordinated Care Planning conference like? Who is involved? Is the physician involved? Who leads the conference?

A Care Conference may include a short meeting to brief providers new to the Coordinated Care Planning process prior to the patient joining the team for the full, 30-60 minute conference. The full Care Team typically meets face-to-face, in a setting that is most comfortable for the patient/client (e.g. their home, their primary care clinic). However, technology may be leveraged to include people for whom face-to-face participation is difficult. For example, a specialist from an urban centre may join a conference in a rural setting via telephone or video conference. Additionally, for those patients/clients/families who may find it difficult to leave home, they may participate with the assistance of someone from the care team via video conference technology.

The patient/client’s primary care practitioner is typically part of the Care Team (described previously) and is, therefore, often present for the conference or a portion of the conference.

The discussion informs the creation of a Coordinated Care Plan (CCP), which is focused on how the Care Team can support the patient/client in reaching his/her hopes and goals. From a facilitation perspective, the Lead typically leads the conference. The Lead is typically someone with an existing, trusting relationship with the patient/client or someone who can easily develop a new relationship.

The CCP is documented on a provincially standardized document and shared with the full Care Team following the conference.

# What happens if the patient/client supports the Coordinated Care Planning process but does not want to participate in the conference?

Although this situation would be the exception, as long as the initial meeting with the individual has been completed so that all Care Team members are able to focus the conference on how each of them will support his/her goals, the conference can proceed without the patient/client. In the spirit of patient-driven care, this approach should only be employed at the request of the patient/client.

# What are the roles and responsibilities of the Coordinated Care Planning Team?

All care team members involved in an individual’s Coordinated Care Plan (CCP) are responsible for:

* those actions agreed upon within the CCP, including fulfilling their portions of system navigation/service delivery for the patient/client
* notifying the Lead of changes in patient/client status or any other changes affecting the CCP
* maintaining or improving communication amongst providers (both those within and external to their organization), regarding updates in status/planning for the individual

The full Coordinated Care Planning team shares in the effort to support the individual to meet his/her personal goals, as agreed upon in the CCP.

# Can more than one person be the Lead?

Yes, the Lead model depends on the patient/client. In some cases, one provider may bring strengths related to experience with facilitating and documenting conferences. A second provider may already have an existing, trusting relationship with the patient/client and/or a deeper understanding of his/her needs. In situations like this, it is recommended that a ‘partner approach’ or ‘mentorship/coaching’ model be adopted.

# What are the different leadership models?

| **A**  **Single Organization Leads** | **B**  **Partner Approach** | **C**  **Mentorship/Coaching** |
| --- | --- | --- |
|  |  |  |
| **Provider from organization who has relationship with individual** | **2 Providers Co-Lead (e.g. Care Coordinator from LHIN Home Care + Provider from another organization who has relationship with individual)** | **Provider from organization who has relationship with individual + Provider experienced with Coordinated Care Planning** |

# 

# What is the difference between “Care Conferencing/Patient Rounds” vs. “Health Links approach to Coordinated Care Planning”?

We know that providers have been conferencing/meeting to discuss patient/client care for many years. We hope that the following table assists in highlighting what is new or different with the Health Links approach to Coordinated Care Planning:

|  |  |  |
| --- | --- | --- |
| **Type of Conferencing** | **Care Conferencing/Patient Rounds** | **Health Links Approach to Coordinated Care Planning\*** |
| **Multiple Providers contribute to plan/conference** | **YES**  Typically only healthcare providers | **YES**  Typically, involves more people, including those beyond the healthcare sector |
| **Patient/Client consents to Process** | **NO**  Not required as long as discussion includes only providers considered within ‘circle of care’ | **YES**  Patient/client involvement required to ensure that approach is patient-driven, considers the ‘whole person’, and includes people outside of the ‘circle of care’, as appropriate |
| **Patient/Client is consulted as to who participates in the Process** | **NO**  Participation is typically dictated by the location in which the patient/client is interacting with the system (e.g. hospital, community partners) and current providers engaged | **YES**  Patient/client input is required to ensure a ‘whole-person’ approach to wellness and to ensure that the right people are involved to support his/her hopes, goals and needs |
| **Conference and Care Planning is driven by Patient/Client’s Goals** | **NO**  Providers conference in order to set a plan for the patient/client | **YES**  Coordinated Care Planning is patient-driven and heavily relies on all partners understanding and supporting the patient/client wishes and goals in order to build a plan with him/her |
| **Conference/Plan is documented in each Provider’s own format/system** | **YES**  Each provider typically documents his/her portion of the plan in his/her own system; the patient/client typically does not receive a copy | **NO**  All Coordinated Care Plans (CCPs) are documented and shared with all partners, electronically or in hard copy, including the patient/client, healthcare providers and non-healthcare partners |
| **Patient/Client is present and actively participating at the conference** | **NO**  Providers conference or round in order to set a plan for the patient/client; patient/client sometimes present at conference | **YES**  Patient/client is usually an active participant at the conference; in rare cases, the patient/client may decide that s/he wishes to not be present at the conference |

\* The Health Links approach to Coordinated Care Planning embraces the strengths of an interprofessional team approach to overall wellness. It considers the “whole person” – mental, physical, emotional and spiritual health.

# I am thinking about Coordinated Care Planning for one of my clients/patients. Who can I talk to learn more about it?

For more information about Coordinated Care Planning and how you can lead, connect with local, in-person resources:

Elgin, [elginhealthlink@eefht.ca](mailto:elginhealthlink@eefht.ca)

Grey Bruce, [healthlink@sbghc.on.ca](mailto:healthlink@sbghc.on.ca)

Huron Perth, [huronperthhealthlink@npfht.ca](mailto:huronperthhealthlink@npfht.ca)

London Middlesex, [healthlink@thamesvalleyfht.ca](mailto:healthlink@thamesvalleyfht.ca)

Oxford, [oxfordhealthlink@cmhaoxford.on.ca](mailto:oxfordhealthlink@cmhaoxford.on.ca)

# For more information, documents and tools, go to: http://swhealthlinks.southwesthealthline.ca

# I would like to establish a Coordinated Care Plan for one of my clients/patients. What should I do?

For more information about Coordinated Care Planning and how you can lead, connect with local, in-person resources:

Elgin, [elginhealthlink@eefht.ca](mailto:elginhealthlink@eefht.ca)

Grey Bruce, [healthlink@sbghc.on.ca](mailto:healthlink@sbghc.on.ca)

Huron Perth, [huronperthhealthlink@npfht.ca](mailto:huronperthhealthlink@npfht.ca)

London Middlesex, [healthlink@thamesvalleyfht.ca](mailto:healthlink@thamesvalleyfht.ca)

Oxford, [oxfordhealthlink@cmhaoxford.on.ca](mailto:oxfordhealthlink@cmhaoxford.on.ca)

For individuals who need Home and Community Care Services through the South West LHIN and Coordinated Care Planning, please complete a referral form: <https://tinyurl.com/LHINreferral>

To discuss Coordinated Care Planning for a specific individual across the South West LHIN, call: 1-855-371-6337 (Monday-Friday 8:00am-4:00pm)

# For more information, documents and tools, go to: http://swhealthlinks.southwesthealthline.ca

# Who has access to the patient/client information and the Coordinated Care Plan?

The patient/client determines who is on the Care Team, with an understanding that the Care Team members will actively participate in the development, sharing, and implementation of the care plan. By controlling who is on the Care Team, the patient/client controls who accesses information that would be included in the Care Plan.

# How are determinants of health, such as housing, considered and addressed as part of the Health Links approach?

Patient/client goals lie at the heart of the Coordinated Care Planning process. If the determinants of health pose barriers/challenges to meeting those goals, the care team will work with the patient/client to best mitigate those challenges. The care team may be built/expanded, if agreed to by the patient/client, to include members who might be most aware of, or can assist with, access to resources such as social assistance, housing, or transportation.

# How and where is the Coordinated Care Plan documented?

The Coordinated Care Plan (CCP) is to be documented on the Provincial CCP template. All Coordinated Care Plans are to be documented and stored in CHRIS (LHIN Home and Community Care electronic medical record).

It can be documented electronically directly into CHRIS or via HPG. The plan can also be completed in a paper format (Word document) and then faxed into the South West LHIN for transcription into CHRIS and shared with Care Team members via fax/paper. The CCP template can be found at: <http://www.southwesthealthline.ca/healthlibrary_docs/CoordinatedCarePlanningTemplate_v2.1_English.docx>

# Does the patient get a copy of the care plan?

Yes. The patient/client/caregiver receives a paper copy of their care plan.

# How is the Coordinated Care Plan shared? How is technology being used (e.g. ClinicalConnect)?

Once Coordinated Care Plans (CCPs) are in the CHRIS system, they are viewable in CHRIS, via Health Partner Gateway, and in the ClinicalConnect viewer. For the patient/client/caregiver (or other providers without access to the aforementioned systems), a printed copy of the CCP is shared.

# How do I know if someone has a Coordinated Care Plans (CCP)? (e.g. How would I know if someone at the Emergency Department has a CCP?)

In Grey Bruce, there is an “alert code # 1” flag that is visible on the banner bar of the hospital electronic records. This code alerts the provider that a CCP exists and can be viewed through Clinical Connect.

We are planning to implement electronic flags in Hospital Information Systems across the South West LHIN. Currently, it is recommended that any provider interacting with any patient/client ask him/her if s/he has a CCP.

# Where can I find existing Coordinated Care Plans?

Coordinated Care Plans (CCPs) can be viewed in CHRIS, via HPG or in ClinicalConnect. Patients/clients/caregivers and Care Team members without access to these electronic platforms will have paper copies of CCPs.

# When is a Coordinated Care Plan considered complete/closed?

A Coordinated Care Plan (CCP) is a fluid document that adapts with the person, as their conditions / situation / goals change over time. A CCP is closed when the patient/client and care team decide that a Coordinated Care Plan is no longer needed, a person withdraws consent for Coordinated Care Planning or the patient/client dies.

# How are primary care providers compensated for their involvement in the Coordinated Care Planning process?

Billing for common Coordinated Care Planning related activities may be found in the Schedule of Benefits.

# When do I use the LHIN Home and Community Care Referral form?

This form is used for requesting Home and Community Care Services from the South West LHIN. This form may also be used to request Coordinated Care Planning for a patient/client that would be led by a Care Coordinator from the South West LHIN lead.

# What is the Registration Form for?

The registration form is to be completed for any paper based CCPs (new or edits) that are being submitted to the LHIN to be transcribed into CHRIS (LHIN Home and Community Care electronic medical record - EMR). This form is also to be completed when organizations external to LHIN Home and Community Care are using HPG to create a CCP in CHRIS. This form provides the Patient’s Consent for their information to be stored in the EMR and provides the necessary information for CHRIS patient file creation and Coordinated Care Planning evaluation needs.

# What happens if the patient/client doesn’t consent for his/her Coordinated Care Plan (CCP) to be stored in CHRIS?

If a patient/client does not consent for their CCP to be stored in CHRIS, you may proceed (with their consent) with Coordinated Care Planning. The patient/client will need to be informed of the implications of their CCP not being in CHRIS -- that their information will not be available to other providers or parts of the healthcare system (e.g. emergency departments) and therefore, providers may not know what is most important to them, or what is involved in their care plan. In this case, the CCP would be documented in Word and shared via fax/paper among Care Team members.

# What is Health Partner Gateway (HPG)?

Health Partner Gateway (HPG) is a system that enables organizations external to LHIN Home and Community Care to access CHRIS (LHIN Home and Community Care electronic medical record). HPG is currently available to Primary Care organizations, but will be rolled out to other organizations (who are Health Information Custodians) that are interested in leading Coordinated Care Planning.

A readiness assessment is to be completed and submitted to the South West LHIN. Network Sharing Agreements (NSA)/Data Sharing Agreements (DSAs) will need to be signed, and privacy and HPG training undertaken before organizations can use HPG to document Coordinated Care Plans (CCPs).

Training for leading Coordinated Care Planning will be undertaken before HPG access is granted. Organizations will not be able to create CHRIS files for patients, but will complete a Registration form to enable the LHIN to create a file for the patient in CHRIS, and then the organization will be able to create the CCP within CHRIS via HPG. For more information about HPG, please refer to the HPG FAQs.

# Where do I find the surveys to provide feedback about personal experience with Coordinated Care Planning?

The feedback survey for providers is available online at: <https://www.surveymonkey.com/r/HL_Provider_Feedback>.

The patient/client/caregiver survey is located at: <https://www.surveymonkey.com/r/HL_Client_Caregiver_feedback>.

# What ministries are involved in implementing the Health Links approach?

At the provincial level, the Ontario Ministry of Health and Long Term Care has been directly involved in funding and supporting the Health Links approach across the province. However, at the patient/client level, organizations/people supported by other ministries are most certainly involved in Coordinated Care Planning (e.g. Ministry of Municipal Affairs and Housing, Ministry of Community and Social Services).

# What are both the intended and realized impacts of the Health Links approach?

The overall aim of the Health Links approach to Coordinated Care Planning is to support patients/clients and families, with high care needs, to be able to live well in their community and reduce avoidable healthcare utilization. In the South West LHIN, we are currently tracking the following indicators:

* Number of Emergency Department (ED) visits before and after Coordinated Care Planning
* Number of Hospital Admissions before and after Coordinated Care Planning
* Hospital Length of Stay before and after Coordinated Care Planning
* Experience of patients/clients/family/supports with the Coordinated Care Planning process
* Experience of providers with the Coordinated Care Planning process

As of July 2018, more than 3000 people in the South West have experienced Coordinated Care Planning.

As of March 31, 2018:

* the rate of unscheduled visits to the emergency department for residents supported by a Coordinated Care Plan (CCP) declined by 35% within 3 months, and 26% within 6 months of their initial care conference date;
* the rate of unplanned admissions to hospital for residents supported by a Coordinated Care Plan (CCP) declined by 38% within 3 months, and 35% within 6 months of their initial care conference date.
* On average, the total number of days stayed in hospital for residents supported by a Coordinated Care Plan (CCP) declined by 5.0 days within 3 months, and 6.4 days within 6 months, of their initial care conference date.

Patient/client/family feedback confirms they feel respected throughout the process and that it is making a difference.

Coordinated Care Planning has the opportunity for improving efficiencies. In one example, a patient/client was connected with multiple dietitians, from various agencies with specific disease management focus. The Coordinated Care Planning process highlighted and eliminated this duplication in service.

In other cases, especially where people have been under-serviced or under-utilizing healthcare services, additional resources may be allocated in order to better support the individual.

# How can I be kept ‘in the loop’ regarding how the Health Links approach is progressing across the South West LHIN?

Contact Amber Alpaugh-Bishop (amber.alpaugh-bishop@lhins.on.ca) to sign-up for our bi-monthly eBlast or to request someone come and speak to your organization, committee, or other group about the Health Links approach to Coordinated Care Planning in the South West LHIN.