NSM Guide to Coordinated Care Planning (CCP) in Health Partner Gateway (HPG)

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Introduction

Coordinated Care Planning

Coordinated Care Planning is the process of engaging all participants in a patient's care team, including the patient and caregivers to ensure a holistic, patient driven approach.

Coordinated Care Planning includes:

- Care conferences
- Individualized care plans based in the patient's expressed goals and needs
- Continuous updating and follow-up as required and as predetermined by the patient and his/her care team

Patient Identification

Health Link target population:

- Patients with four (4) or more chronic/high cost conditions
- Complex, high need patients
- Vulnerable population
- Economic characteristics
- Social determinants of health

Health Partner Gateway (HPG) and Care Plan Access

Beginning in 2018, Health Link partner organizations will use Health Partner Gateway (HPG) to document and share Coordinated Care Plans (CCP) by all team members. HPG is a portal with limited data from the Home and Community Care client record system (CHRIS).

Access to the CCP is managed by NSM LHIN and will be granted based on the team members identified in the *Coordinated Care Plan Consent*. Members of the care team with access to HPG may be able to view, add and update a CCP, depending on the permissions set by their organization. Team members with access will receive automatic email notifications of changes to the plan.

Roles

Lead Organization

Organizations who are initiating the CCP process will act as the Lead. The role of the lead may transfer to another organization following the care conference or at any point during the patient's care.

The role of the Lead includes:

- Initiating discussion with the patient regarding Coordinated Care Planning
- Obtaining consent to proceed with a coordinated care plan and obtaining the list of the Care Team members in discussion with the patient
- Initiating the Coordinated Care Plan
- Arranging and facilitating the Coordinated Care Conference if required
- Documenting and Sharing the Coordinated Care Plan
- Management of ongoing consent including adding or removing health care partners as patient goals are met and added

Partner Organization

When a partner is requested by the Lead to participate in a Coordinated Care Plan, the partner will contribute to the Coordinated Care Plan and attend Coordinated Care Conferences as required.

The CCP will be initiated by the Lead agency in HPG. The Care Team members will receive an email notification when the plan has been updated by any member of the team. The role of the partners includes:

- Identifying with the patient relevant goals and developing the action plan
- Documenting the goals and action plan related to how they are supporting the patient on the CCP
- Updating the 'More About Me' information relevant for care team members or the patient
- Participating in Case Conferences and/or communicating with the Lead
- Informing the Lead the patient is in hospital or inputting 'My Most Recent Hospital Visit'

Patient/Caregiver

Patients/caregivers have the following role:

- Consent to a CCP if in agreement
- Identify who is currently involved in their care
- Share their health care and lived experience
- Engage in exploring their goals and needs
- Participate in Coordinated Care Conference(s)
- Work towards achieving their goals and needs as per the CCP
- Adhere to the communication and follow-up strategy as determined during the Coordinated Care Conference

Coordinated Care Plan Consent – *Collected by the Lead*

Consent is obtained from a capable patient. Refer to PHIPA hierarchy for the appropriate substitute decision maker (SDM), if the patient is incapable and follow agency policies.

1. Partner organizations will collect consent from the patient (or authorized SDM) for their participation in the coordinated care planning process
    - Express consent to store the plan in HPG is collected by the Lead organization
2. A *Coordinated Care Plan Consent* form has been developed for all five (5) Health Links in NSM. This form will be completed by the Lead and faxed to NSM LHIN for patient registration.
3. The Patient/SDM may apply restrictions to the consent. Ask questions to understand what they want to restrict or limit. Specific restrictions can be set in the 'Restrictions' box on page 1:

Restriction	Action Required by Lead
Connecting Ontario Restriction	Document the restriction and submit the form to the NSM LHIN. Upon receipt of the consent form, LHIN Team Assistants will forward the form to the Privacy Team to action. A member of the NSM LHIN Privacy and Records department will be in touch with you for next steps.
NSM LHIN Employee Restriction	Document the restriction and submit the form to NSM LHIN. Upon receipt of the consent form, LHIN Team Assistants will forward the form to Privacy to action. The NSM LHIN Privacy and Records department will apply a local restriction, and will follow up with you if clarification is required.
Organization Restriction	By default, organizations are not given access to a patient's CCP in HPG unless they are identified on the Consent form page 2. If the patient would still like to include an organizational restriction, the Lead will be responsible for managing this restriction locally. If applicable, the Lead will let other Care Team organizations know of the restriction.
Employee Restriction for Partner Organization on the Care team (non-LHIN employee)	The Lead navigator will inform their Privacy Officer (PO). The PO will work with the PO from the organization with the restricted employee to ensure a possible and reasonable solution is reached.
HPG Restriction	If the above restriction types do not satisfy the patient/SDM request related to a restriction and consent is not provided for the CCP to be managed in CHRIS-HPG, the plan will be completed on paper or within an EMR and shared using pre-HPG processes. Document that patient did not provide consent for CHRIS-HPG (for your local documentation purposes).

4. The second page of the consent form lists the members of the care team. It should include all members of the Care Team. This form will be also used to set the appropriate CCP permissions in HPG. Partner organizations with HPG access are already listed on the Consent form. Select 'Add to Care Team' as needed.

5. As a lead, identify with the patient individuals who are part of the patient's care team. This may include, but is not limited to:

   - Patient
   - Substitute decision maker (SDM)
   - Family
   - Primary Care Provider
   - Community Service Agencies
   - Health Service Providers
   - Community Care Coordinator
   - Hospital Care Coordinator
   - Other participants

   The team members are identified by the patient. There should be a minimum of two (2) team members to meet the "Basic Coordinated Care Plan" criteria.

   On the consent check the box 'Add Care Team' beside the organizations which are part of the Care Team. Write or type in the other Care Team members. All team members should be listed even if the organization/care team member does not have access to HPG.

   As the lead, you will check off the box 'Lead Organization' beside your organization.

6. Care Team members will be documented in the Coordinated Care Plan and members will receive an automatic notification email when a plan is started if on HPG. The Lead is responsible for sharing the plan with Care Team members not on HPG. If requested, the Lead organization will share the HPG consent with the Care Team members.

7. Care Plan Access will require updating based on any changes to the consent including the revoking of access when a team member is removed from the list or the patient is discharged / Care Plan completed. The Lead will send the NSM LHIN the following form: *NSM Health Links CCP Registration/Update/Discharge Form* (Section B).

SECTION B:	Request to Add/ Revoke Coordinated Care Plan Permissions	
Add Permissions ☐		Revoke Permissions ☐
Organization name:		
Add Permissions ☐		Revoke Permissions ☐
Organization name:		
Consent received: Yes ☐		

8. In section B, click 'Add Permissions' or 'Revoke Permissions' and enter the organization who will have permissions changed. Discuss and gather verbal consent from the patient. Click Consent received: Yes. Fax this form to NSM LHIN. (Note, do not fill out and submit this form for non HICs or those without HPG access, as no permissions changes in HPG are required. Instead, add/remove the non-HIC or partner organization in the 'My Care Team' section of the CCP.)

Coordinated Care Conference - *Completed by the Care Team*

The Lead will work with the patient and the team to determine details of the Conference including where, when and how. Ideally this will be conducted at the patient's convenience.

1. Invite all team members to care conference as listed on the consent
2. Facilitate the care conference with care team and patient/family
3. The below script can be used when speaking with the Care Team members.

Hello PARTNER NAME,

A mutual patient,________________(*patient name*), has consented to developing a Coordinated Care Plan. To further develop the plan, we are organizing a Coordinated Care Conference with members of the patient's Care Team. The purpose of the Coordinated Care Conference is to collaborate with the patient, other health care providers involved in his/her care and his/her informal supports to develop a plan to support (patient name) in achieving the goals that (he/she) has expressed. The patient has requested that you attend this Care Conference, which will take place on ____(date) at___________(time) via ________________________________(teleconference, in-person, and videoconference).

TELECONFERENCE NUMBER:__________________PIN ___________

During the Coordinated Care Conference, the patient and each member of the Care Team will:

- Listen to the patient explain his/her needs and health care goals; and
- Have the opportunity to discuss the most appropriate social and health care services for the patient's plan of care.

After the Coordinated Care Conference, you will be informed of Coordinated Care Plan updates and in turn, you will be asked to update the patient's Coordinated Care Plan when appropriate.

Involving the Care Team in the Care Plan – *Completed by the Lead*

Ideally every patient would have the benefit of a Coordinated Care Conference. Patients who have multiple complex goals, or who are at risk of hospitalization, would likely benefit most from a Coordinated Care Conference.

For patients who do not need a Coordinated Care Conference, a CCP can be developed with the patient and shared with the team for input. Team members with access to HPG will receive an automated email notification that a new Care Plan has been initiated for a patient in their care. For those team members without access to HPG, the plan must be faxed with an accompanying template letter to ask them for their input into the plan.

Health Links Coordinated Care Plan TEAM Template Letter:

Re: Coordinated Care Planning

Dear CARE TEAM MEMBER,

You have been identified as part of the Care Team for________________________(Patient Name).

A Coordinated Care Plan (attached) has been developed to support the patient in achieving their goals and to communicate with all of their Care Team, what is most important to them. The Care Team will collaboratively work together to support the patient in achieving these expressed goals.

As members of the Care Team we are collectively responsible for maintaining the accuracy of the Coordinated Care Plan. Please share any updates to the patient's care that should be reflected in the Coordinated Care Plan. We (the Lead) will update the Care Team as changes are made to the Coordinated Care Plan.

Name:
Organization:
Please contact me by:

- ☐ **Fax:** ________________________________
- ☐ **Phone:** ________________________________
- ☐ **Other** ________________________________

Thank you and I look forward to working with you.

Registration in HPG – *Completed by the Lead*

The Lead organization facilitates registration.

1. To start a plan with a new Health Links patient, send the required registration information to the NSM LHIN by faxing to 705-792-6270 or 1-866-700-1955. Include all 3 forms in the SAME FAX:
   - Health Link Referral Form (as per your Health Link)
   - *Coordinated Care Plan Consent*
   - *NSM Health Links CCP Registration/Update/Discharge Form (Mandatory fields and Section A)*

2. Fill out the patient information section, Section A and Submission Details at the bottom.

North Simcoe Muskoka Health Links

Coordinated Care Plan (CCP) Registration/ Update/ Discharge Form

Form to be completed by lead organization and returned to NSM LHIN via fax:

1-866-700-1955 or 705-792-6270

PLEASE COMPLETE SECTION A, B, C, D, or E, AS WELL AS PATIENT AND SUBMISSION DETAILS SECTIONS. ALL FIELDS IN ANY GIVEN SECTION ARE MANDATORY.

PATIENT	
Name: Amanda Doe	
HCN: 123456231 VL	
SECTION A: Request for CHRIS/ HPG Registration	
Please register this patient in CHRIS/ HPG	✓
Referral and CCP Consent attached with registration (required)	✓

3. NON-LHIN HOME AND COMMUNITY CARE Patients will be registered in CHRIS/HPG by an NSM LHIN Team Assistant (TA) and assigned:
   - a Health Links referral and placeholder caseload to keep the CHRIS file active
   - a Health Links Client Code to indicate the specific HL (Muskoka, Barrie etc.) for reporting capabilities

4. Existing LHIN HOME AND COMMUNITY CARE patients are already registered in CHRIS so a NSM LHIN Team Assistant (TA) will assign:
   - a Health Links referral
   - a Health Links Client Code to indicate the specific HL (Muskoka, Barrie etc.) for reporting capabilities
   - The caseload will not be changed

After receiving the correct documentation, new patients will be registered in 36 hours or less. For existing HCC patients, permissions for the CCP will be set in 36 hours or less. NSM LHIN will fax back the *NSM Health Links CCP Registration/Update/Discharge Form* to the lead to indicate permissions have been set.

Editing the CCP – *Completed by the Care Team*

The team members with access will update the CCP directly in the HPG system. For those without access, they will send any edits or corrections back to the Lead to transcribe. The Care Team will determine the plan for ongoing follow up, timelines etc.

The Coordinated Care Plan will be reviewed and updated when there is any significant change in patient status or at time of reassessment. Team members with access to the CCP through HPG may update the plan when required.

Triggers to update and share the Coordinated Care Plan with patients/non HPG partners:

- Changes to acuity and /or social determinants of health
- Changes in goals and/or plan which may be due to admission to/discharge from health programs or a hospital stay

Lead Updates:
The Lead has overall responsibility for initiating and updating the plan. The Lead will be the partner who, at a minimum, initiates these sections:

- My Identifiers
- My Care team
- Health Care Consent and Advanced Care Planning
- What's Most Important to me and My Concerns
- My Goals and Action Plan

Partner Updates:
Partners will update the following sections:

- My Goals and Action Plan
- More About Me
- My Most Recent Hospital Visit

Guidelines:

- Data standards for completing the fields in the Care Plan are established by Health Quality Ontario (HQO): *Coordinated Care Plan User Guide V2.*
- This guide includes additional instructions/data standards as needed
- The plan remains IN PROGRESS until all goals are met. A patient will only have more than one plan if they have been discharged and re-admitted to the Health Link approach.
- Care Team members will receive automatic email notifications when the plan has been edited. Using the Audit Log in the CCP, Care Team members can see what areas have been viewed or updated.
- Care Team members will save a copy of the care plan after they have made edits by clicking 'Generate PDF' and filing the electronic plan in their EMR/Point of Care System so they have a copy of the latest plan. This is a temporary step required until HPG functionality is updated and does not allow you to overwrite text.
- NEVER DELETE anyone else's text from the plan. Work with the author to make corrections.
- Only input what is important for the team or patient to know.
- ALWAYS SAVE each section after you change it. HPG will not let you update a new section until you save/clear changes in the last section.

Initiation of the CCP

A CCP can be added by the Lead 36 hours (or less) after sending NSM LHIN registration documentation. The Lead will be faxed back the Registration form and to indicate permissions are set.

Initial information can be documented in the CCP through discussion with the patient and members of the health care team. Integrate the care planning and goal setting conversation as part of the regular routine during initial assessments and reassessments. Initiate discussion of patient goals with the patient (a minimum of one (1) patient goal is required for a basic Coordinated Care Plan).

1. Login to HPG with your credentials
2. Add a new Care Plan by clicking on the Add Care Plan button. If a Care Plan has been previously entered, you will be brought to the latest Care Plan.
3. The “created date” and “created by” field populate with current system date and the HPG logged in user.

The basic plan must include:

- MY IDENTIFIERS (auto populated)
- MY CARE TEAM (minimum of two (2) members)
- WHAT’S MOST IMPORTANT TO ME AND MY CONCERNS
- HEALTH CARE CONSENT AND ADVANCE CARE PLANNING
- MY GOALS AND ACTION PLAN (minimum of one (1) goal updated as required)

Other sections should be completed as additional information is available to enhance the CCP.

My Identifiers – Completed by the Lead

Some of the demographic information in CHRIS will auto-populate into the CCP under the MY IDENTIFIERS section of the plan. To add the additional ‘Identifers’ information, click the UPDATE SECTION, make your changes and save the Care Plan by clicking the button at the bottom of the section.

To navigate through the plan you can scroll down or click on the appropriate section at the top of the plan. A user can update one section at a time. You must save before moving to another section.

My Care Team – Completed by the Lead

The name, role and telephone number of the team members will be documented in the MY CARE TEAM section of the CCP.

1. The Team members have been identified by the patient during the consent process. Include <u>all</u> members of the Care Team listed on the consent form. Specific notes can be documented under the Role or Relationship (e.g. dtr- finances only).
2. By clicking the 'Coordinating Lead' radio button, the Lead will appear in the top of the My Care Team section. There can only be one lead.
3. Once all team members have been documented, click SAVE THE CARE PLAN at the bottom of the section.

My Care Team (Include active family/caregivers, providers)						
Coordinating Lead (notify if patient is hospitalized)		Name: Chris Handley		Phone Number: 705-236-2654		
Name of Team Member	Role	Organization	Contact Information		Share Coordinated Care Plan	Coordinating Lead
			Primary Number	Secondary Number		
Chris Handley	CC	LHIN	705-236-2654	--	Yes	◉
Amanda Leigh	Navigator	District of Muskoka	705-123-1236	--	Yes	○

What's Most Important to me and My Concerns – Completed by the Lead

See HQO User Guide: *Coordinated Care Plan User Guide V2*

Health Care Consent and Advance Care Planning – Completed by the Lead

See HQO User Guide: *Coordinated Care Plan User Guide V2*

There are some sections that are completed by the partners, including the Lead:

My Goals and Action Plan – Completed by the Care Team

1. Each partner will input their goals with the patient. Below is a sample:

My Goals and Action Plan (Cancel Changes | Clear Form)

What I hope to achieve	What we can do to achieve it	Details	Who will be responsible	Date goal identified	
Secured housing	application to DOM for subsidized housing	connecting with Housing team -	Emily - Care Navigator	17-Jul-2018	Remove
Independence with Bathing	PSW 2x weekly to assist with personal care	OT DO PSW waitlisted	Ruth - Care Coordinator	17-Jul-2018	Remove
Not be so depressed	socialization Adult Day Program	Coordinator to apply for Day Program	Nicole - SASOT	19-Jul-2018	Remove

Add a new goal

2. Once the goal is complete, type 'Goal met' and the date after the goal in 'What I hope to achieve section'

My Goals and Action Plan (Cancel Changes | Clear Form)

What I hope to achieve	What we can do to achieve it	Details	Who will be responsible	Date goal identified
Secure housing GOAL MET - 2018-08-01	Application to DOM for subsidized housing	Work with DOM to connect with housing team	Amanda - Care Navigator	09-Jan-2018

More About Me – Completed by the Care Team

Care Team members can update notes in this section. There is no character limit. Include your initials and date (YYYY-MM-DD) after your notes.

More About me

Cancel Changes | Clear Form

Topics	Details	
Income		
Employment		
Housing		
Transportation		
Food security		
Social network		
Health knowledge		

Appendix 3 – My Most Recent Hospital Visit – Completed by the Care Team

If partners become aware the patient is in hospital, they should notify the team by completing Appendix 3 – 'My Most Recent Hospital Visit'. A automatic notification email will be sent to the care team on HPG. The Lead should inform members of the Care Team not on HPG. Whoever is first aware of the patient's discharge will complete the Date of Discharge and Save. This is not historical. If a patient is discharged and goes to hospital later, this section would be cleared and re-completed.

Appendix 3 - My Most Recent Hospital Visit

Cancel Changes | Clear Form

Hospital Name: HDMH **Visit Date:** 17-Jul-2018

Reason for Visit: fracture hip - admission to hospital

Visit Description: ○ Emergency room to home ◉ Emergency room to inpatient unit

Date of Discharge: ddMMyyyy **Length of Stay:**

Comments:

↥ Back to top | Save Care Plan

Appendix 4 – Palliative Approach to Care – Completed by the Care Team

If the patient is palliative refer to Home and Community Care.

Removing your Organization from HPG

If the patient has completed the goals related to your organization, or if you have discharged the patient:

1. Open the latest CCP and 'Generate PDF'. File and save this as the latest plan in your EMR/Point of Care system.
2. Inform the lead organization you are revoking your permissions
3. Complete the 'Revoke Permissions' section of the below form and fax it to the NSM LHIN:
    - *NSM Health Links CCP Registration/Update/Discharge Form*
4. Once permissions are removed, you will not have access to the CCP.

Note: if you are the lead organization and you have discharged the patient, speak with the Care Team to assign a new lead. Share the appropriate forms with the new lead as needed.

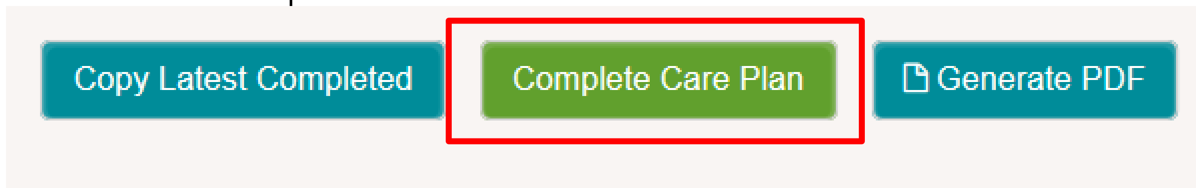
- Update the Lead radio button in the CCP 'My Care Team'

Completed Care Plan / Discharge

A Care Plan may be considered complete for a variety of reasons, for example:

- Patient Death
- Patient or family preference
- Service plan complete (dramatic change in Clinical status, no longer requiring CCP)
- Transfer to another LHIN

1. The Lead will 'complete' the Care Plan.



2. The Care Plan Access must be REVOKED for all team members on HPG when the Care Plan is ended. The Lead organization will fax the Update form to NSM LHIN:
    - *NSM Health Links CCP Registration/Update/Discharge Form (Section C)*

SECTION C:	Discharge Health Links Referral			
Date of discharge (yyyy-mm-dd):				
Discharge disposition:				
Died *(Complete section C1 also)* ☐	Service Plan Complete ☐	Patient/ Family preference ☐	Transfer to other LHIN ☐	Other ☐
Service Plan Goals Met: Yes ☐	No ☐			
SECTION C1:	*Only complete if client died*			
Date of death (yyyy-mm-dd):				
Location of death:				
Home ☐	Hospital ☐	LTCH ☐	Palliative Care/ Hospice ☐	Other ☐
Client passed away in preferred place of death: Yes ☐			No ☐	

3. The Health Link Client Code, referral and caseload will be end dated/closed by the NSM LHIN Team Assistant. For NON LHIN HOME AND COMMUNITY CARE patients registered in CHRIS for Coordinated Care Planning, the CHRIS file will be closed.
4. The Lead organization will inform the other Care Team members about the discharge status as needed.
5. If a patient has been discharged and now requires re-admission to the Health Link approach, please re-complete the registration and start a new plan.

CCP in HPG Privacy Policies

The organization who manages the HPG tool (Health Shared Services Ontario (HSSO)), developed seven (7) supporting privacy policies for partner organizations:

1. *HPG Acceptable Use Policy*
2. *HPG Access and Correction Policy*
3. *HPG Consent Policy*
4. *HPG Incident Management Policy*
5. *HPG Inquiries and Complaints Policy*
6. *HPG Privacy Audit Policy*
7. *HPG Training Policy*

These policies are adopted by any organization with viewing or editing rights to CCPs and are put in place to ensure all organizations have consistent direction when managing privacy issues that may include multiple partner organizations.

Audit Reporting

Privacy Officers of partner organizations may request access reports to support their auditing processes using the audit report request form:

- *CCP Audit Report Request Form*

1. Email the completed form to NSM.HealthRecords@lhins.on.ca
2. A member of the Privacy and Records department will contact you.
3. The request will be reviewed and report shared through the HPG Inbox which was set up when HPG access was granted to your organization.
4. Privacy Officers will have 14 days to retrieve the reports from HPG
    - Log-in to HPG using your credentials
    - Select the Document Exchange tab → Inbox and open the linked report

Contacts

IT Issues:
HPG degradation can be reported to the NSM LHIN Help Desk:

- 705-721-8010 x2293.

Support hours will be Monday to Friday from 8:30 a.m. to 4:30 p.m.

If a degradation or planned outage occurs, partners will receive (an) email bulletin(s) indicating the reason, action being taken and planned up-time.

Urgent plans will be completed on paper until they can be transposed into HPG.

Privacy and Health Records Issues:
The Privacy and Records department should be contacted in the following cases:

- An electronic CCP was created for the wrong patient (Strikeout is required)
- Audit Report request (see process above)
- Discussing a restriction that does not follow one of the pre-defined scenarios (CCP Consent Section)

Contact: NSM.HealthRecords@lhins.on.ca or 705-721-8010 x6641

Questions about this Guide:
Please email the LHIN Health Link Lead: Kim.Sontag@LHINS.on.ca . Do not include PHI in your email.

Coordinated Care Planning Tools

- Nsmhealthline.ca Coordinated Care Planning Documents/Resources
- NSM LHIN CCP Registration/Update/Discharge form
- CCP v2 HQO Guidelines
- CCP Consent Form
- CCP Audit Report Request Form