# Coordinated Care Management

## Document the Coordinated Care Plan

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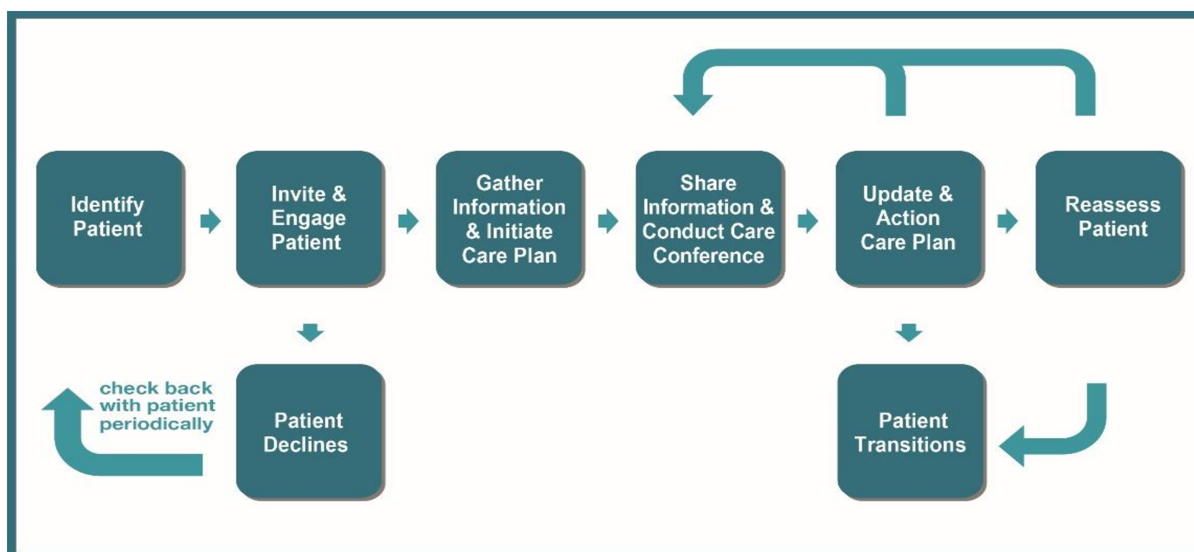


***Figure 1: Approach to Coordinated Care Management***

While this approach to Coordinated Care Management is generally accepted across the province, there is **significant variation in the *practices* within each process step**. Although each practice, organization, region, and/or Health Link may have varying areas of foci, the following collection of Innovative Practices and implementation supports are designed to **support teams to improve care for patients within the Health Link, and to support the ongoing alignment and advancement of consistent practices at a provincial level**. *For additional information on Quality Improvement, please visit:* ***qualitycompass.hqontario.ca/portal/getting-started***.

### The Care Coordination Tool

One of the key outputs of **Coordinated Care Management** is the development of a **Coordinated Care Plan (CCP)**. As described by the Ontario Medical Association, "a coordinated care plan is a written or electronic plan that is created and maintained by the patient or his or her family, the health care team including physician consultants where appropriate, and when necessary, community services. […] It outlines the patient's short and long-term needs, recovery goals, and coordination requirements, and it identifies who is responsible for each part of the plan."[1]

In collaboration with a provincial, cross-sectoral/interdisciplinary focus group, the Ministry of Health and Long-Term Care (MOHLTC) developed a standardized **Care Coordination Tool** for use by Health Links. While Health Links are not *mandated* to use this template developed by the MOHTLC, **79% of Health Links reported that they are using the provincial CCP template**[2]. Some Health Links have implemented various processes using the paper-based version of the tool, and sharing it with other members of the care team via fax or by other secure means, while others are exploring and/or implementing electronic platforms to document, share, and update the CCP.

[1] Ontario Medical Association. Key Elements to Include in a Coordinated Care Plan [Internet]. Ontario: Ontario Medical Association. 2014 June [cited 2016 June]. Available from: *https://www.oma.org/Resources/Documents/CoordinatedCarePlan_June2014.pdf*

[2] Health Quality Ontario. Health Links Quarterly Report for the period July to September 2015. Ontario: Health Quality Ontario; 2015.

*The material for Coordinated Care Management was developed in collaboration with Health Links and the Clinical Reference Group.*

## Electronic Platforms for Documenting, Sharing, and Updating the Coordinated Care Plan

Health Links and the MOHLTC have identified that a secure, electronic platform may be a key enabler for documenting, sharing, and updating the coordinated care plan. The MOHLTC engaged a selection of Health Links in a Proof of Concept project in 2015 and 2016 to explore the electronic Care Coordination Tool (eCCT), a platform designed "to create, share and view coordinated care plans and exchange secure messages within the circle of care for Health Link clients"[3]. An evaluation of the eCCT is currently underway. Also, a comparative evaluation of "other major care coordination solutions that have been implemented in different parts of the province in the last 1-2 years"[4] is scheduled to take place over the remainder of 2016. *For additional information, please refer to **www.hqontario.ca/quality-improvement/tools-and-resources**.*

### Implementation

| Steps for Implementation | Tools and Resources |
|---|---|
| 1. Develop the Coordinated Care Plan (CCP) using the above approach to Coordinated Care Management (including obtaining informed consent to share the CCP with the care team).<br><br>2. Document the plan using the CCT template (typically managed by the single point of contact), and ensure that there is a process in place for updating and sharing it. It is essential that all members of the care team be aware of this process, and their responsibilities within it.<br><br>3. Distribute the CCT to the care team, using fax, other secure methods and/or an electronic solution.<br><br>4. Follow the process in place for updating the CCP, then document using the CCT and re-distribute, as indicated. | • **Coordinated Care Plan User Guide** (Ministry of Health and Long-Term Care, 2015).<br>• **Coordinated Care Plan Detail** (Ministry of Health and Long-Term Care, 2015)<br>• **Coordinated Care Plan Summary** (Ministry of Health and Long-Term Care, 2015) |

## References


- Health Quality Ontario. Health Links Quarterly Report for the period July to September 2015. Ontario: Health Quality Ontario; 2015.
- Ministry of Health and Long-Term Care. Coordinated Care Plan User Guide. Ontario: Ministry of Health and Long-Term Care. Ontario: Ministry of Health and Long-Term Care; 2015 [cited 2016 June]. Available from: *www.hqontario.ca/quality-improvement/tools-and-resources*
- Ministry of Health and Long-Term Care. Care Coordination Tool (CCT): Proof of Concept Project Update February 2016 Q's & A's. Ontario: Ministry of Health and Long-Term Care; 2016 [cited 2016 June]. Available from: *www.hqontario.ca/quality-improvement/tools-and-resources*
- Ontario Medical Association. Key Elements to Include in a Coordinated Care Plan [Internet]. Ontario: Ontario Medical Association. 2014 June [cited 2016 June]. Available from: *https://www.oma.org/Resources/Documents/CoordinatedCarePlan_June2014.pdf*


[3] Ministry of Health and Long-Term Care. Coordinated Care Plan User Guide. Ontario: Ministry of Health and Long-Term Care. Ontario: Ministry of Health and Long-Term Care; 2015 [cited 2016 June]. Available from: *www.hqontario.ca/quality-improvement/tools-and-resources*

[4] Ministry of Health and Long-Term Care. Care Coordination Tool (CCT): Proof of Concept Project Update February 2016 Q's & A's. Ontario: Ministry of Health and Long-Term Care; 2016 [cited 2016 June]. Available from: *www.hqontario.ca/quality-improvement/tools-and-resources*


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