HealthLink / Maillon santé

Greater Sudbury/du Grand Sudbury

Coordinated Care Planning Toolkit

This toolkit has been adapted with permission of the Central East Health Links.

For more information contact:
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Background

Who should use this Toolkit?

This toolkit is intended for any individual or organization who is participating in Greater Sudbury Health Link coordinated care planning – as a Greater Sudbury Health Link Liaison, Lead Care Coordinator or member of a care team.

What is the purpose of the Toolkit?

The Coordinated Care Planning Toolkit provides care team members with information, tools and resources to support the invitation, engagement and coordinated care planning for individuals participating in the Greater Sudbury Health Link. Detailed information related to various Greater Sudbury Health Link processes are provided in the linked tools and resources. All tools and resources are available directly via the Greater Sudbury Health Link webpage - http://sm.cmha.ca/programs-services/greater-sudbury-health-link/

NOTE: *All Greater Sudbury Health Link templates, tools and resources are to be used in accordance with the current Personal Health Information Protection Act (PHIPA), 2004 and the organizational policies of care team members.*

What is the Greater Sudbury Health Link?

Ontario's Ministry of Health and Long-term Care, in partnership with Local Health Integration Networks, supports the establishment and operation of Health Links across the province. Each local Health Link is structured to reflect the specific context of its community. All, however, are guided by the common goal to improve the coordination of care for individuals with complex health and social needs.

The Greater Sudbury Health Link (GSHL) seeks to improve the well-being of Sudbury residents who require a wide range of services and supports. This often includes individuals who are challenged by multiple chronic conditions, mental illness, addictions, developmental disability and poor access to the social determinants of health, (e.g. income, housing, social supports).

The Greater Sudbury Health Link brings individuals together with their full team of health and community service providers. They work together to identify each individual's unique care goals and make plans to achieve them. Members of care teams may include primary care providers, specialists, allied health professionals, community health and social service providers and other informal caregivers.

Relevant Tools:

What is the Greater Sudbury Health Link: Information for Health and Community Service Providers?

How will the Greater Sudbury Health Link help me and the people I serve/support?

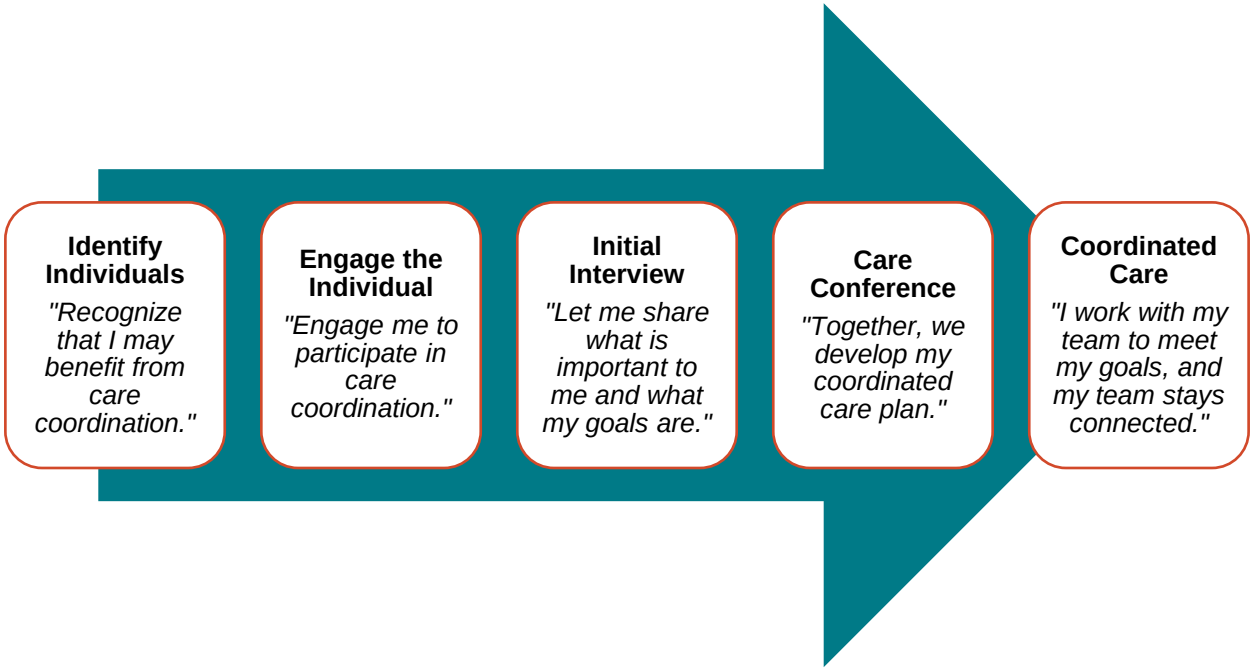
With improved coordination, communication and access to support, it is hoped that individuals with complex health and social needs will have improved outcomes and require fewer health interventions. This may include reduced primary care visits, ED visits and hospitalizations, duplicated lab work, tests and assessments, etc.

- *Lead Care Coordinators* will be the first point of contact for individuals who have questions about their care plans. They will help them, and other members of the care team, to access and navigate the range of services and supports that are needed.

- Coordinated Care Plans will mean that all providers will have access to the most current information about an individual's health, treatments, care team members and goals.

- Working together, individuals and care teams can explore creative and collaborative options for achieving care goals.

Greater Sudbury Health Link Process and Practice



How are individuals referred to the Greater Sudbury Health Link?

If you are working with an individual who you feel could benefit from Greater Sudbury Health Link care coordination, please contact the Greater Sudbury Health Link, c/o Canadian Mental Health Association – Sudbury/Manitoulin at 705-675-7252, healthlinkinfo@cmha-sm.on.ca. You may also refer to the Greater Sudbury Health Link Referral Form for more information about eligibility considerations.

Relevant Tools:

- *Greater Sudbury Health Link Invitation Script: Guide for Providers*
- *What is the Greater Sudbury Health Link: Information for Individuals and Caregivers?*
- *Greater Sudbury Health Link Referral Form*

Greater Sudbury Health Link Liaisons

Greater Sudbury Health Link Liaisons are trained care providers that are familiar with GSHL processes, tools and approaches. GSHL Liaisons are housed within the following collaborating partner agencies:

<table>
<tr><th colspan="2">Greater Sudbury Health Link Liaison Agencies</th></tr>
<tr><td>Canadian Mental Health Association – Sudbury/Manitoulin</td><td>North East Community Care Access Centre</td></tr>
<tr><td>Centre de santé communautaire du Grand Sudbury</td><td>Sudbury Community Service Centre</td></tr>
<tr><td>Monarch Recovery Services</td><td>Réseau ACCESS Network
HIV Program
Hepatitis C Program</td></tr>
<tr><td colspan="2">Health Sciences North – Mental Health & Addictions Programs
Assertive Community Treatment Team
Developmental Clinical Services
Positive Steps Program
Primary Care and Medication Support</td></tr>
</table>

At the time of referral, providers are asked to select the most appropriate GSHL Liaison agency, based on the individual's needs, goals, existing connections with care providers, and preferences. This agency will confirm the individual's participation, work with them to start their GSHL *Coordinated Care Plan*, and coordinate their first Care Team Conference.

What is a Coordinated Care Plan (CCP)?

The *CCP* includes the individual's:

- care goals;
- care team members - people/providers/agencies;
- health history and medications;
- daily routines, and how they manage everyday tasks;
- plan outlining who will assist with each part of their plan.

All *Coordinated Care Plans* are stored electronically in the database of the North East Community Care Access Centre (NECCAC). *Greater Sudbury Health Link Liaisons* and most *Lead Care Coordinators* will be able to access and update CCPs directly via the NECCAC Health Partner Gateway. Changes to an individual's care plan are then communicated to all team members, ensuring that everyone has consistent, up-to-date information and is working towards common goals.

Relevant Tools:

- *The Greater Sudbury Health Link Coordinated Care Plan*
- *The Coordinated Care Plan Feedback/Consultation Request*
- *The Coordinated Care Plan Update Template*

I have been identified as a Lead Care Coordinator for an individual I work with? What is my role?

Every individual in the GSHL has an identified *Lead Care Coordinator* who is selected from among the individual's full care team. *Lead Care Coordinators* should be chosen with the individual's preference considered first. Ideally, the role will be assumed by the organization/individual who has a good relationship with the individual and is best aligned with the individual's health needs and goals. Sometimes, if they are a member of the individual's care team, the Greater Sudbury Health Link Liaison may continue in the *Lead Care Coordinator* role. In other situations, it may be more appropriate for another care team member to take the lead. In those cases, the Greater Sudbury Health Link Liaison will remain a resource to the *Lead Care Coordinator,* available to answer questions about GSHL tools and processes.

As a Greater Sudbury Health Link *Lead Care Coordinator*, you are a central point of contact for both the individual/patient and members of the care team. You agree to use the GSHL tools and processes for coordinated care planning and play an important role to help individuals access and navigate the range of services and supports that are needed to meet their wellness goals. Some of your activities may include:

Lead Care Coordinator Roles and Activities	
Facilitate communication between all care team members (including the individual and caregivers)	• act as a “go to” for members of the care team when they have questions about the content of the Coordinated Care Plan • ensure that consent forms are up to date and shared with all care team members • share updated CCPs with all care team members • facilitate regular opportunities for sharing and collaboration between care team members (care team meetings, teleconferences, other check-ins) • coordinate the establishment of care team distribution lists within the Health Partner Gateway so that all care team members are notified when changes have been made to a CCP
Update and maintain Coordinated Care Plans	• ensure appropriate access to CCPs via the NECCAC Health Partner Gateway • receive CCP updates from care team members • make updates to the electronic CCP within the NECCAC Health Partner Gateway
Navigate and help to access supports and services required by the individual	• work with the individual and care team members to identify gaps in existing service and support • assist with appropriate referrals • keep track of when/if appropriate services/supports do not exist or are not accessible • think creatively about ways to assist the individual to meet their wellness goals

Relevant Tools:

- *The Greater Sudbury Health Link Coordinated Care Plan*
- *Greater Sudbury Health Link Participant Consent to Release Information*
- *Planning Your Care Workbook*
- *The Coordinated Care Plan Feedback/Consultation Request*
- *Coordinated Care Conference Recommendations*
- *The Coordinated Care Plan Update Template*

I have been identified as a member of someone's care team. What is my role?

As a health or community service provider, you (or your agency) may be identified as a member of an individual's care team, i.e. someone who is either currently providing services or provides a service that is required for an individual to meet their care goals. If you are a required member of someone's care team, you will be contacted by their *Greater Sudbury Health Link Liaison* or *Lead Care Coordinator* and asked to:

- contribute to their *Coordinated Care Plan (CCP).* This may be at an in-person care conference or through another mutually decided process.
- communicate updates to the *Lead Care Coordinator* in order to make any necessary changes to the individual's *CCP*
- maintain the most current version of the *CCP* in your own agency service/medical records.
- collaborate with other members of the care team in order to best support individuals to achieve their care goals.

Relevant Tools:

- *The Greater Sudbury Health Link Coordinated Care Plan*
- *The Coordinated Care Plan Update Template*

Obtaining Consent

The Greater Sudbury Health Link Participant Consent to Release Information form must be signed by the patient or their Substitute Decision Maker (SDM) before proceeding with the coordinated care planning process. Successful coordinated care planning requires communication and information sharing between all members of a care team including the patient and caregivers.

The Greater Sudbury Health Link Consent Form permits members of the care team to request and release Personal Health Information with all individuals/organizations listed and consented to on the form. Additionally, the consent form states that Personal Health Information will only be shared for purposes of planning the patient's care and improving the health care system.

Consent can be refused or withdrawn at any time by contacting the individual's *Lead Care Coordinator*. Furthermore, patients can add/remove individuals/organizations at any time. The *Lead Care Coordinator* will be responsible for sharing the most current version of the consent with all members of the care team.

Relevant Tools:

- *Greater Sudbury Health Link Participant Consent to Release Information*