Enabling Health Links with a Care Coordination Tool

February 2014
Health Links highlighted the need for a care coordination tool

- Health Link business plans consistently highlight how technology could enable their objectives from patient identification to care coordination. They need tools to:
  - **Create, maintain, and share coordinated care plans**; and
  - **Send secure messages** about patient care to providers from different sectors and organizations.

- If these actions were easier to do consistently and securely,
  - **Patient goals** would be recorded and known to all members of the care team and clinicians would have more information, all recorded in the same place, to **plan and deliver care based on those goals**;
  - Duplications or gaps in care could be more easily spotted and fixed;
  - Clinicians could **communicate more quickly** about patient’s care.
The ministry’s analysis showed there is no existing ehealth system that is provincially available that can meet all Health Link requirements.

However, there are ehealth systems that, with some modifications and improvements, can be used to meet Health Link needs.

The Integrated Assessment Record, which already has thousand of registered users and stores millions of clinical records, can be modified to create the CCT.

The CCT would enable secure messaging between providers in a patient’s care team and will allow members of the care team to create, maintain and share coordinated care plans.

In time, the CCT will be more fully integrated with patient Electronic Health Records and point of care systems and provide different options for how patients can access their coordinated care plans.
Journey to a Care Coordination Tool

Step 1
Coordinated Care Plan (CCP)
- Objective: Establish a coordinated care plan template that can be used by providers for patients within a Health Link
- Products:
  - A paper version of the coordinated care plan
  - Business requirements needed to begin development of an electronic version

Draft CCP Completed

Step 2
Objective: Work with Health Links to setup key providers within Health Links with access to a dynamic, online coordinated care plan
- Products:
  - Dynamic web-enabled care plan
  - Secure messaging within a Health Link
  - Visibility of a patient’s Circle of Care
  - Business requirements needed to begin development of an electronic version

Step 3
Objective: Integrate key ehealth solutions within Health Links into the CCT solution
- Products:
  - Bi-directional updates between CCT and local Point-of-Care systems (within HL)
  - ED Notification and Discharge Summary
  - Partial automatic update of Care Plan based off interface feeds

Step 4
Objective: More robust integration with other provincial sources of data
- Products (forecasted):
  - Community assessments populating areas of the coordinated care plan
  - EMR upload of visit summaries / cumulative patient profile
  - Consumption of provincial cornerstone systems (Client/Provider Registry)
Health Links themselves defined the coordinated care plan (CCP)

From August to November 2013, 3 plenary and 7 breakout sessions were held in Toronto, Hamilton, and Ottawa to develop a CCP template.

- HQO’s literature review framed and guided the discussion
- Existing Health Link CCPs were used as the basis for a draft
- Participant discussion and experience shaped the draft into its current form

Over 40 Health Link participants

- Clinicians, project managers and LHIN planners
- Physicians, nurses, mental health workers and allied health
- Cross-section of rural, suburban and urban Health Links
- Different Health Link care coordination models
- Drawn from nearly 20 Health Links and all 14 LHINs
- Hospitals FHTs, CHCs, CCACs, CSSs and mental health services
Snapshot of the coordinated care plan template

- Identifiers
- Patient goals and care plan
- Advanced care planning information
- Care team members
- Health conditions and issues
- Social history
- Assessments
- Recent hospital visit
- Social supports
- Medications
- Other treatments
- Key daily routines
- Upcoming appointments

Please contact evan.mills@ontario.ca to receive a copy of the most recent version of the Coordinated Care Plan template
Moving forward

- The ministry is again partnering with Health Quality Ontario to run a series of focus groups to continuously improve the tool and the coordinated care plan template based on experience.

- Two focus groups have already started:
  - One focus group is for Health Link clinicians and project managers, tasked with improving the coordinated care plan template specification;
  - The second focus group is for patients and caregivers involved with Health Links – to gather their insights and perspectives.

- Focus groups that address other topics, such as data integration and secure messaging, will be added when they are needed.
CCT rollout plan

Year 1
- 3 months: CCT Go-Live
- 6 months: New releases twice a year
- 9 months: Future functionality to be added:
  - Timeline view of major episodes of care and visits
  - More integration with existing ehealth systems

Year 2
- 12 months: Future CCT Development
- 15 months: Future CCT Implementation Phases
- 18 months: Ongoing CCT focus groups

CCT Release 1 Development
- CCP authoring and sharing
- Secure messaging within the circle of care
- Access to community assessments

CCT Implementation Phase 1
- Deployment preparation
- User registration
- Solution and privacy training

Future CCT Implementation Phases
- New releases twice a year
- Ongoing CCT focus groups
Ministry commitments

Business requirements will continue to drive decisions on enabling technology

Health Links will be our partners throughout the life-cycle of this initiative

CCT will complement existing point-of-care systems and eHealth Ontario’s regional connecting projects

We will strike a balance between taking the time to properly reflect Health Link requirements – and getting a tool into the hands of Health Links