

Making the Coordinated Care Plan (CCP) Work: Chronic Disease Management that Matters

What's in the Coordinated Care Plan?

The CCP includes critical patient information to facilitate patient safety and care continuity for patients with complex care needs.

Important considerations that may not already be in the patient chart include, advance care planning, patient goals, and all members of the care team.

This is a living document that can be updated as changes occur.

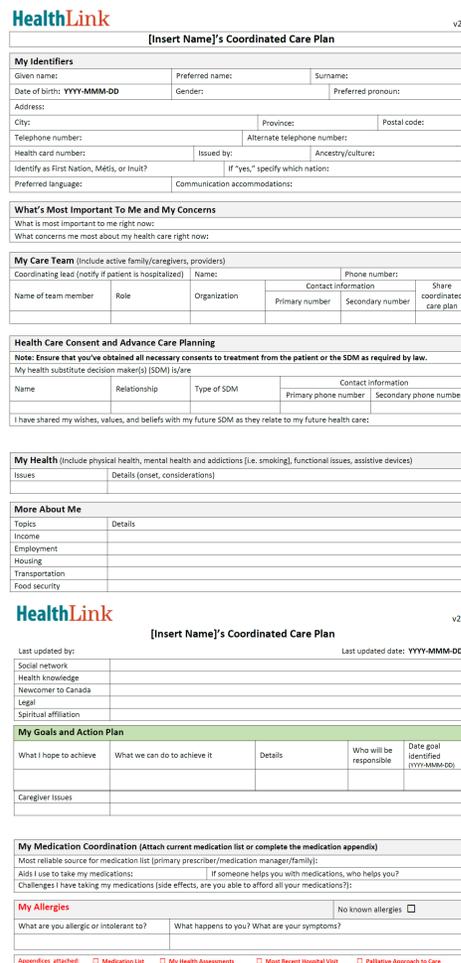
Coordinated Care Plans:

- Help facilitate an interdisciplinary approach by enhancing communication, ensuring patient priorities are set and made clear, as well as ensuring that clinical work is not repeated.
- Place patients at the center of their care, ensuring that their wishes do not fall through the cracks.
- Ensure that important care needs are not overlooked, e.g. advance care planning.

Identifying Priority Patients

Priority patients were offered an enhanced assessment and CPP initiation, and were identified using these specific criteria for program involvement.

These lists were cross referenced and those who were involved in the most categories were listed as the highest priority.

Coordinated Care Plan in Action

In order to take an interdisciplinary approach to CCP and ensure time efficiencies the priority patients are being offered enhanced joint visits, predominantly by the nurse practitioner and pharmacist, however team members are selected based on patient needs and goals.

Integrating the Electronic Medical Record (EMR)

The CCP was modified as a custom form in the EMR (Practice Solutions), and a direct link was developed from the Ocean toolbar.

The patient profile displays the last day that the document was updated, so that all providers recognize that there is an active CCP.

Collapsible sections allow only that which pertains to the patient to be seen, simplifying the appearance. The document and appendices are auto-populated as applicable.

Evaluation

In order to evaluate the usefulness of the CCP for the identified patients, a follow-up will be conducted 6-12 months after the implementation to identify whether the goals were respected, if it has been updated appropriately, and that it is still in use.

Additionally, a survey will be conducted at this time to evaluate provider satisfaction, including time spent, ease of use, and value added.

Next Steps

- Evaluate the usefulness of the CCP document for the identified patients and make appropriate changes.
- Implement an efficient system to share the CCP with outside partners.
- Discuss how to give patients access to update their CCP as needed.

The Coordinated Care Plan was developed by the Health Link and is to be implemented in its' current form without changes, for continuity across the system.

Please do not hesitate to contact our team for more information about implementing CCP at your FHT