

## **CO-ORDINATED CARE PLAN TEMPLATE:**

### **Guide for Completion**

#### **Introduction:**

The purpose of the Coordinated Care Plan (CCP) Template is to have a standardized and concise reference guide about what is important to know about a patient if you are providing care or being asked to join the patient's "circle of care" providers. This template should be completed through a process of dialogue between the patient and his/her circle of care, guided by the patient's goals of care. Any member of the care team, including the patient and family, can complete sections of this template.

The CCP Template is to be shared and referred to by patients, their families, and their care providers to promote a common understanding of the patient's health-related conditions, goals of care, and preferred strategies to achieve identified goals. The CCP should be accessible to the patient and his/her care providers. Every effort should be made to keep the care plan up-to-date.

#### **Guiding Principles:**

1. The Care Plan Template is intended for use in all adult populations with complex health needs.
2. Any member of the circle of care can contribute to completing the care plan, including the patient and/or any person authorized by the patient. If it is completed by one member of the care team, it should follow appropriate dialogue and consultation with the patient and circle of care.
3. The circle of care providers include the patient's family physician, community care access care providers, specialists, other community or health care providers and any person identified by the patient as important to their health and care.
4. Health conditions include current conditions that are having an impact on the person's health status and may include:
  - a. Determinants of health (e.g. housing, income, social & physical environment, safety, health literacy)
  - b. Medical diagnoses
  - c. Mental health conditions
  - d. Substance use
5. Safety Net and Care Goals are based on patient-centred dialogue which is informed by the circle of care.
6. Action Plan can include any actions by any member of the circle of care that are related to achieving the person's goals of care. The person accountable for these actions should also clearly specified.
7. The Advance Plan section of the template should be informed by an Advance Care Planning Process which was developed by the East Toronto Health Link and is available at: <http://sunnybrook.ca/content?page=CCP-toolkit>

#### **Getting Started:**

1. Invite the patient to participate in planning his/her care by providing information about the importance of Coordinated Care Planning can be done by any member of the patient's circle of care. A Brochure for

patients and families about care planning is available at: <http://sunnybrook.ca/content?page=CCP-toolkit>.

2. Invite members of the patient's circle of care to participate in care planning with the patient. A Brochure for family physicians about care planning is available at: <http://sunnybrook.ca/content?page=CCP-toolkit>.
3. Identify a Care Coordinator who will initiate the care planning process and begin to complete the template. This role can be filled by a CCAC Care Coordinator or any member of the patient's circle of care. The Toronto Central CCAC is working with its Health Links Partners to assign a care-coordinator to each physician so that they can work together on a regular basis to ensure optimal care coordination for complex patients. Access to these services can be found at: <http://healthcareathome.ca/torontocentral/en/Partners/Health-care-Providers> or at 416-310-2222.
4. The Care Coordinator:
  - a. contacts the patient to meet and review demographic information, information about the existing circle of care, and to begin a discussion about the patient's Safety Net and Care Goals.
  - b. contacts the Family Physician to obtain information about the patient's health conditions, circle of care, and current medication list.
  - c. contacts the patient's pharmacist to confirm the current medication list.
  - d. sets up a meeting of the patient, family member (if requested by the patient), the family physician, the Care Coordinator and any other appropriate member of the patient's circle of care.  
Teleconference and secure videoconferencing (via OTN) may be used to facilitate this meeting.
5. At the Care Planning meeting (s):
  - a. review what is most important to the patient/family
  - b. review patient's goals of care
  - c. patient's current and anticipated health conditions
  - d. preferred strategies to achieve identified goals and reduce health risks.

It may not be possible to achieve a plan of care after one meeting so follow-up meetings may be required.
6. The Care Coordinator then:
  - a. reviews the completed Coordinated Care Plan Template with the patient to confirm accuracy
  - b. makes any revisions as appropriate.
  - c. shares a copy of the completed CCP with the patient and the circle of care.
  - d. instructs the patient to bring the completed CCP Template to all health care visits, including the Emergency Department and specialists.
7. All members of the circle of care, including the patient/family, are responsible for notifying the Care Coordinator when updates or changes are required to ensure the CCP Template remains up-to-date and shared. A communication plan for sharing updates will be in place.

