2014/15 Integrated Complex Care Advisory Committee Action Plan Priorities

The Integrated Complex Care Advisory Committee was established in January 2014 with provincial representation across the following stakeholder groups:

- Families with children who have complex health needs
- Youth with complex health needs
- Paediatric specialists
- Primary care
- Community, regional and tertiary paediatric hospitals
- Community and social service agencies
- Local Health Integrated Networks
- Research and Innovation

The Advisory Committee reported to the PCMCH and had working groups to advance the 2014/15 action plan priorities listed below:

- **Confirming the initial target population:** Data analyses completed by the Institute for Clinical Evaluative Sciences illustrated that the most significant paediatric health care costs are incurred in the care of children whose heath care needs place them in the top 1% for health service utilization. This group predominantly consists of children with clinical conditions that are associated with children medical complexity (CMC) who are medically fragile and/or technology dependent (neurological impairment, multiple system complex chronic conditions, and/or dependent on medical technology).

- **Endorsing an end-state strategic framework:** At the 2014 Provincial Symposium, over 140 diverse stakeholders from across Ontario endorsed a Strategic Framework for Integrated Care and Coordination for Children with Medical Complexity. This strategic framework articulates both an end-state vision for integrated complex care and coordination and the nature of the processes, people and tools required to achieve this shared vision.

- **Developing a standard operational definition for CMC who are MFTD**: With input from family and cross-sector provider representatives, a standard operational definition for Children with Medical Complexity (CMC) who are Medically Fragile and/or Technology Dependent (MFTD) (See Attachment B) was developed and endorsed by PCMCH. This tool will promote a common understanding among all stakeholders of the children that comprise the target population, consistent identification across the province of CMC who are MFTD and equitable access to integrated care and coordination for these children.

- **Developing a Toolkit to Support Effective Collaboration within an Integrated Care Team:** To help integrated care teams (defined as teams consisting of family members as well as team members from various organizations and sectors who do not typically work collaboratively as one team), PCMCH and its partners developed a toolkit to help integrated care teams understand the behaviours required to overcome the challenges and barriers to effective collaboration. The toolkit is a living document that will evolve with ongoing input from PCMCH partners.

- **Defining the requirements of a Care Plan Tool for children relative to adults:** PCMCH stakeholders have consistently identified the development of an electronic care plan as the key enabler for integrated care and coordination. As a first step in defining the path for achieving

this goal, PCMCH engaged an Expert Panel to confirm the key contents and user requirements of a care planning tool to support integrated care and coordination for children with complex needs. PCMCH then assessed the extent to which these needs are addressed in the Health Links care planning tool being developed to support adults with complex needs. Recognizing that the Health Links tool would not meet the needs of children, PCMCH drafted a separate tool for children.

- **Recommending a path forward for establishing an Electronic Care Plan tool for children:** PCMCH identified and completed a high-level qualitative review of existing electronic platforms that could be leveraged to enable an electronic care planning tool for CMC and the integrated care teams that support them. Recommended next steps included partnering with the MOHLTC to complete the additional analysis required to select the preferred platform and the next steps associated with the development of an electronic solution for kids.

- **Completed a leading practice review to support improved coordination of clinical visits within Ontario's tertiary paediatric hospitals**: In addition to improving cross-sector and cross-organizational care coordination, we committed to improving the coordination of visits within the organizations and sectors that support CMC starting with Ontario's tertiary paediatric hospitals. To support the development of action plans to improve coordination of clinical appointments for children with medical complexity within tertiary hospitals, a current state and leading practice review was completed and each of the tertiary paediatric hospitals established action plans.

- **Advocating for increased flexibility in home care services for CMC**, including the introduction of direct funding as an option – both of which were reflected in the Donner Report and in the government's recent roadmap for improving home and community care.

- And, last but not least, **developing a strategy, and multi-year implementation plan, for advancing integrated medical care and coordination for CMC** (the *'Complex Care for Kids Ontario'* strategy) that is complementary to both the Health Links initiative and the Coordinated Service Planning component of the Ontario Special Needs Strategy.