PRACTICE GUIDELINES

Recommendations for Effective Collaboration Between Home and Community Care Support Services Care Coordinators and Complex Care for Kids Ontario Nurse Practitioners

MARCH 2024

HOME AND COMMUNITY CARE SUPPORT SERVICES

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EXECUTIVE SUMMARY

Background and Objective

In June 2023, the Provincial Council for Maternal and Child Health (PCMCH) and Home and Community Care Support Services (HCCSS) convened a working group to develop practice guidelines to strengthen, align and standardize the relationship and protocols between HCCSS care coordinators (CCs) and Complex Care for Kids Ontario nurse practitioners (NPs). The following four recommendations were developed through collaborative discussion and provider engagement.

Practice Recommendations for Adoption

- **Participation in Clinic Visits**: CCs should consistently prioritize and attend CCKO clinic visits either virtually or in-person.
- **Access to CCKO Medical Care Plans**: All providers in the patient's circle of care should have access to a current CCKO medical care plan. When a medical care plan is updated, it should be recirculated to everyone within the circle of care.
- **Consistent and Complete Medical Orders**: Providers should ensure that all medical orders sent between NPs and CCs are complete with the minimum required data set listed in Appendix B.
- **Coordinated Discharge and Transition to Adult Care**: CCs and NPs should use the Complex Care for Kids Ontario Youth Transition to Adult Care Toolkit to proactively work together to promote smooth transitions for CCKO patients.

Supplementary Materials

Further to these four practice recommendations, other resources have been developed and included as supplementary materials to ensure successful adoption of these guidelines. These include: processes to support each recommendation's implementation, a provider roles and responsibilities section, a CC clinic visit checklist, a medical order form minimum data set, and an example of a current regional process that has proven to be successful.

These practice recommendations are intended to serve as overarching principles to be integrated into routine practice. Further, this resource is to prompt and guide a series of change management conversations between local CC and NP groupings. Given the local differences that exist across regions, teams are advised to work through and plan specific details of implementing these guidelines to ensure successful adoption.

Launch, Implementation and Evaluation

The practice guidelines were endorsed by the CCKO Leadership Table at PCMCH and HCCSS in March 2024. Providers are to initiate implementation by July 2024 (the start of Q2 FY 2024/2025). The delayed roll-out date is to allow teams to work together to effectively communicate the change in process and prepare for implementation. An evaluation is planned six months after roll-out to determine utilization and uptake of the practice recommendations, with a full evaluation planned after at least one full year of implementation to assess effectiveness and the overall success of the practice guidelines.

INTRODUCTION

The Provincial Council for Maternal and Child Health (PCMCH) and Home and Community Care Support Services (HCCSS) have come together to develop practice guidelines to support and standardize the relationship and protocols between HCCSS care coordinators (CCs) and Complex Care for Kids Ontario nurse practitioners (NPs).

Complex Care for Kids Ontario (CCKO) is a provincial program led by PCMCH to improve service delivery, health and quality of life in meeting the needs and requirements of children/youth with medical complexity (CMC) and their families. CCKO coordinates care across health and social support services and strengthens community services to improve access and enable care closer to home.[1] The CCKO model of care utilizes individualized medical care plans to facilitate this care coordination by streamlining information sharing and consolidating clinical visits.[2]

A core component of the model is the assignment of NPs who play a central role in the program by providing medical care coordination in hospital settings and maintaining strong connections with social support services, including the HCCSS CCs, to support patients and families in resource and service navigation in the community.

Ontario's 14 Home and Community Care Support Services organizations coordinate and provide in-home and community-based care for patients and their families across Ontario, supporting patients to maximize their health and wellbeing in the place they call home. HCCSS CCs are regulated health care professionals that collaborate with primary care providers, hospitals, Ontario Health Teams and many other health system partners to support high-quality, integrated care planning and delivery.[3]

To effectively execute the coordinated care model that is CCKO, it is imperative that CCs and NPs work collaboratively and in active partnership with the child/youth and their family to optimize scope of practice and provide integrated and high-quality care. Though patients and/or families can withdraw consent for provider communication, optimal care is facilitated by strong provider alignment and active sharing of information within the patient's care team.

Purpose

The purpose of these guidelines is to strengthen, align and standardize the relationship and protocols between HCCSS CCs and CCKO NPs. This includes but is not limited to supporting role clarity in order to:

- optimize equitable care to all CMCs and their families across the province;
- optimize all roles in order to enhance patient outcomes and experience;
- enable all those involved (NPs, CCs, patients, families, service providers, and school staff) to manage expectations and streamline communication;
- promote complementary and collaborative work between the two provider groups; and
- create efficiency in supporting protocols and information exchange, improving the provider experience and demonstrating wise stewardship of limited human resources across multiple sectors.

APPROACH

A working group comprised of representatives from Home and Community Care Support Services and CCKO tertiary sites was established in June 2023. Recommendations and guidelines were formulated through ongoing discussion and collaboration (see Acknowledgements for working group membership) and endorsed by the CCKO Leadership Table at PCMCH and HCCSS in March 2024.

A NOTE ON HEALTH EQUITY

Advancing health equity across the perinatal, newborn and child healthcare system in Ontario is a priority at PCMCH. Equity is the absence of unfair, avoidable, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g., sex, gender, ethnicity, disability, or sexual orientation).[4] These social determinants of health, and their intersection, can affect the health of individuals, groups, and communities in many different ways. Health equity is achieved when everyone can attain their full potential for health and wellbeing. Addressing the harmful impacts of racism, amongst other factors, is an important step towards achieving health equity. Home and Community Care Support Services (HCCSS) is committed to supporting the achievement of health equity for the diverse communities and patients it serves.

The recommendations outlined in this Practice Guide are meant to strengthen and align the relationship and protocols between HCCSS CCs and CCKO NPs in order to promote a seamless and high-quality care experience for patients and families. When using this guide, healthcare providers (HCPs) are reminded of the many diverse groups and different regions that make up our province. These factors can greatly influence a person's unique needs, expectations, access to services and supports. It is essential to provide culturally safe and client centered care by improving one's knowledge and understanding through various learning platforms and in some situations, to consult with organizations that specialize in supporting specific groups.

PRACTICE RECOMMENDATIONS AND ENABLERS

The following four practice recommendations support a complementary and collaborative approach for CCKO NPs and HCCSS CCs to collectively advance high-quality and equitable care for CMCs and their families. The importance of each recommendation is stated with associated enablers outlining processes to support the recommendation.

PRACTICE RECOMMENDATION	IMPORTANCE	ENABLERS
Participation in Clinic Visits CCs should consistently prioritize and attend CCKO clinic visits either virtually or in-person.	CCKO clinic visits are critical for optimal information-sharing and collaboration between providers.	HCCSS • The CC can attend CCKO visits either virtually or in-person. It is recommended that it is the primary CC who participates in these visits, though a delegate may attend and relay information as required. • If a CC is unable to attend a clinic visit, it is their responsibility to advise the NP and communicate any important information in advance and/or assign a delegate to attend instead. The clinic note should be reviewed as soon as it is received from the NP. CCKO • The tertiary site is expected to inform the CC of their patient's clinic appointment date/time as soon as the appointment is made, preferably at least four weeks in advance. • The tertiary site should strive to minimize last minute schedule changes as much as possible. • The tertiary site is responsible for giving CCs as much notice as possible when there are last minute schedule changes. • Instructions for virtual attendance are to be built into every meeting invite. • The NP is responsible for copying the CC on the clinic note. **Leveraging Successful Regional Processes**: Please see Appendix C for enhanced communication strategies.

Practice Recommendations and Enablers cont'd

PRACTICE RECOMMENDATION	IMPORTANCE	ENABLERS
Access to CCKO Medical Care Plans All providers in the patient's circle of care should have access to a current CCKO medical care plan. When a medical care plan is updated, it should be recirculated to everyone within the circle of care.	It is important that up-to-date medical care plans are available to the circle of care to ensure that teams make appropriate and timely decisions for ongoing care of the child/youth and their family.[5]	• Once the initial CCKO medical care plan is complete, the NP should ensure that it is shared with everyone within the medical circle of care, including CCs. This task may be done by coordinators or admin staff. In the absence of a provincially integrated IT system, the medical care plan may be sent via encrypted email or fax. • A copy of the medical care plan is to be uploaded into the patient's chart. If the patient is part of a satellite clinic, a copy should also be sent to the satellite center for their records. • The medical care plan is to be updated within one month of each follow-up visit, and whenever a patient is admitted to hospital. **Note**: This section is referring to the CCKO Medical Care Plan only.
Consistent and Complete Medical Orders Providers should ensure that all medical orders sent between NPs and CCs are complete with the minimum required data set listed in Appendix B.	It is important that all relevant medical order information is captured accurately and in a consistent manner to ensure timely service delivery and minimize the inherent risk due to errors and omissions.	• Tertiary sites are expected to review current medical order forms and ensure that the minimum data set is captured. See Appendix B for a list of medical order requirements.
Coordinated Discharge and Transition to Adult Care CCs and NPs should use the Complex Care for Kids Ontario Youth Transition to Adult Care Toolkit to proactively work together to promote smooth transitions for CCKO patients.	This is important as the consequences of ineffective transitions can include health deterioration, avoidable hospital admissions, emergency department visits and increased health system costs.[6]	• Both providers should utilize the Complex Care for Kids Ontario Youth Transition to Adult Care Toolkit - Healthcare Provider Checklist as a guide in the process and to proactively address concerns early on before transitioning patients into the adult care system. • When a patient is being discharged from a Complex Care clinic and transferred to a community primary care provider, the NP/tertiary site is to fax a copy of the CCKO medical care plan to the primary care provider (e.g. Pediatrician, Family Doctor, Nurse Practitioner) who will resume care for the child. • Sending the last clinic visit note and/or having a meeting with the new provider is optional though recommended practice to support a seamless transition process.

ROLES AND RESPONSIBILITIES

The purpose of this section is to provide clarity on each provider's roles and responsibilities pertaining to care of CCKO CMCs and their families.

HCCSS CARE COORDINATORS	CCKO NURSE PRACTITIONERS
INTAKE AND ELIGIBILITY	
Assesses and determines eligibility for professional services in the home and/or school setting	Performs new intake assessment in Complex Care clinic to confirm eligibility; identifies alternate sources of care and/or services for ineligible patients or patients who do not require Complex Care services
Establishes HCCSS care plan and coordinates individualized service plans	Orients patient and family to CCKO, providing information about the Complex Care program and defining the roles of team members
Provides system navigation by connecting patients and families to appropriate services and supports in the broader health care system and their local community	Supports patients and families with internal hospital system navigation and connects families to internal resource supports and specialists as needed
CLINIC VISITS	
Prepares for clinic visits by reviewing the Clinic Visit Checklist document (Appendix A), collecting relevant and up-to-date information to bring to the meeting, and inviting any community providers to the clinic visit, as needed	Prepares for clinic visits by reviewing patient information (including current medical care plan, sub-specialty notes, hospital visit/admission notes, and plan from last clinic visit), inviting relevant allied health team members, and proactively considering any medical and/or surgical plans that will require coordination of care
Participates in the clinic visit by sharing relevant reports and updates from home and the community (including from home care nurses, allied health providers, community agencies, school), and sharing any financial, social, and health updates since the last clinic visit	Leads the clinic visit, reporting on any updates from last clinic visit, noting required updates to medical orders, addressing any intercurrent health issues along with review of system-based review of health issues, and leading any conversations around goals of care, advanced care directives, or discharge
Provides any medical order forms and/or applications that need to be signed or completed	Conducts physical examinations
Collaborates with CCKO NP to review and prepare for medical and/or surgical plans that require coordination of care	Collaborates with medical circle of care to review any medical and/or surgical plans that require coordination of care
CCKO MEDICAL CARE PLANS	
Receives the medical care plan and ensures it is attached to the patient care file	Creates a CCKO Medical Care Plan after the first clinic visit and updates at follow-up visits, after admission to tertiary site and/or upon family request
	Ensures all providers in the patient's medical circle of care have access to a current CCKO medical care plan

CARE COORDINATION	
Develops collaborative working relationships with a broad range of community agencies, linking individual patients and families with appropriate resources	Collaborates and consults with the patient's care providers, including any community and allied health services, primary care providers, home care and school services, specialists, tertiary care and Children Treatment Centers/rehab services
Monitors and reassesses the patient on a regular basis and adjusts the HCCSS service plan and coordinated care plan, modifying them in response to changing needs	Collaborates with HCCSS CC and/or social work to ensure appropriate funding and resources are in place; completes forms/applications/letters of support where appropriate
Organizes and leads multi-disciplinary meetings with a community focus (school, home nursing, etc.), including CCKO NP as needed	Attends school meetings when requested to support medical information sharing/plan of care
Liaises with other members of the patient's care team, including school staff, as necessary to advance a coordinated approach to care planning and delivery	Organizes, attends and/or leads interdisciplinary or family meetings with a medical focus (inpatient and outpatient)
	Identifies when medical appointment coordination is required, and delegates to the appropriate person within the clinic
MEDICAL MANAGEMENT	
HCCSS CC, in collaboration with service providers, updates the Complex Care team of any medical changes and informs the CCKO NP of the required changes to medical/nursing/school orders As noted in the limitations section, this process varies across regions. As such, tertiary sites and HCCSS teams are tasked with collaboratively reviewing and refining their own specific process flows regarding medical orders across home and school settings. Regardless of who assumes the role of initiating orders, it is imperative that CCs, NPs and service providers all remain informed of any changes to medical orders.	Primary point of contact for patient and family for health-related concerns: • Management and triage of acute medical issues • Diagnostic reasoning • Assessment and management of inter-current issues • Referrals for specialist consultations or therapists • Medical/nursing/school orders, often in collaboration with the HCCSS CC and/or service provider Primary care is not provided by NPs however NPs will collaborate with primary care providers as appropriate.
Coordinates with CCKO NP to organize education and training from frontline providers to patients/families, and ensures frontline providers are aware of changes to medical plans	Teaches and empowers families to independently manage child's care; liaises with HCCSS CC to organize any additional education and training
Identifies high risk situations/risk events that have an impact on medical management of patient	Acts as a consultant on the management of complex disease entities and technologies
	Engages in advanced care planning with family, patient and care team
DISCHARGE PLANNING	
Promotes and plans for the discharge of appropriate patients through collaboration with the patient, family, members of the health care team, and community partners	Reviews eligibility at each clinic visit and plans for discharge when appropriate
Support transitions due to geography, age, etc. by ensuring a thorough and comprehensive transition to a new geography or an adult caseload for ongoing care coordination	Introduces and highlights the Complex Care for Kids Ontario Youth Transition to Adult Care Toolkit- Healthcare Provider Checklist
Ensures and coordinates education from frontline providers to patients/families	Supports medical transition to adult care by identifying/connecting with an adult primary care provider who will manage care, sharing the medical care plan, offering a handover meeting, ensuring medical circle of care is aware of discharge plans, and providing consultation to new providers as needed

LIMITATIONS

These guidelines are limited in their specificity of pathway directions and processes. Recognizing the regional variation across Ontario, tertiary sites and HCCSS teams are advised to collaboratively determine their own specific processes in alignment with the recommendations captured in this document.

IMPLEMENTATION AND EVALUATION

These guidelines were endorsed by the CCKO Leadership Table at PCMCH and HCCSS in March 2024 and are expected to be implemented by July 2024.

The Provincial Council for Maternal and Child Health and Home and Community Care Support Services are committed to reviewing this document periodically to ensure it serves as a useful tool to strengthen, align and standardize the relationship and protocols between HCCSS CCs and CCKO NPs. An evaluation is planned six months after roll-out to determine utilization and uptake of the practice recommendations, with a full evaluation planned after at least one full year of implementation to assess effectiveness and the overall success of the practice guidelines.

If you have feedback or questions about this document, please email info@pcmch.on.ca.

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Aligning Home and Community Care Support Services Care Coordinator and Complex Care for Kids Ontario Nurse Practitioner Roles and Responsibilities - Working Group: 2023-2024

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APPENDIX A:
CARE COORDINATOR CLINIC VISIT CHECKLIST

This list is intended to guide CCs in preparing for and participating in CCKO clinic visits. The following information should be reviewed with relevant updates collected prior to each clinic visit.

HCCSS Supports

- Services provided/frequency/hours
- Services waitlisted
- Reports from homecare agencies and home care nurses; any challenges in providing care including need for education and training
- Relevant service provider updates; reports from home allied health professions – RD, OT, PT, infant development worker etc.

Community Supports

- Children's Treatment Centre (services)
- Contact agency (CSP, etc.)
- Behavioral supports
- Mental health supports
- Daycare/school updates or outstanding issues; reports from the school and reports related to school meetings
- Respite supports
- Transition to Adult Care status (CCKO transition document)
- Holland Bloorview Kids Rehabilitation Center-PT/OT/SLP
- Reports from home allied health professions – RD, OT, PT, infant development worker etc.

Financial – application needed/ completed/receiving

- ACSD
- SSAH
- Trillium
- Complex Special Needs Funding
- Passport Funding
- ODSP
- OHIP+
- Easter Seals Incontinent Grant
- Access 2 Card
- ODB
- Respite funding (ERF etc.)
- Disability Tax Credit
- ADP
- Jennifer Ashleigh

Health

- Updates regarding any identified changes
- Changes/updates to medical orders needed
- Add/highlight recent hospital admissions

Social

- Changes to family status ie. separation, death
- Caregiver illness
- Significant change to living situation or financial situation
- Concerns/questions that any of the community providers may have

Family Managed Home Care

- Supports in place
- Challenges

Transition - Transition to Adult Services

- ODSP application
- DSO application (including Passport Funding)
- Most responsible physician updated
- Internal HCCSS transfer as appropriate
- School follow-up regarding transition plan process
- Contact (or similar agency) follow-up regarding transitional aged youth process/plan

***Bring any medical order forms and/or applications that need to be signed**

APPENDIX B: MEDICAL ORDER FORM MINIMUM DATA SET

This list is intended to be cross-referenced by tertiary sites to ensure that each component is captured on their medical order form.

(*) Mandatory/required information.

Demographics

- Name*
- DOB*
- Health Card Number*
- Parent/Legal guardian*
- Relevant Dx/Problem list*
- School name
- OH at Home Region
- Home address*
- Telephone 1*
- Telephone 2
- Contact email
- Allergies*

Enteral Feed/Nutrition/Diet*

- Type of feed (formula/blend feeds)*
- Rate/range/frequency/acceptable range/ feeding pump rate if applicable*
- Duration of feeds via ________*
- NPO or can take anything orally*
- Water flushes*
- Type of tube*
- Type of replacement tube*
- Routine feeding tube care*
- Check water in balloon feeding tube devices (specify volume and frequency)*
- Feeding tube stoma care*
- Feeding tube emergency management*

Medication Orders

- New or Update*
- Medication*
- Dose*
- Route* (via Gastronomy Tube or Jejunostomy Tube)
- Frequency (flexibility of timing)*
- Seizure protocol
- Diabetes management protocol

Other Orders

- Order Type – Respiratory
- Suction- Size
- Oxygen Parameters

Supplementary Info

- Order type – School* ☐ YES ☐ NO
- Order type – Home* ☐ YES ☐ NO
- Order type – Combined home and school* ☐ YES ☐ NO
- Equipment

APPENDIX C: LEVERAGING SUCCESSFUL REGIONAL PROCESSES

This section is intended to outline an example of an additional practice that some regions have found successful in promoting effective collaboration between NPs and CCs.

Complex Care Rounds

In between clinic visits, teams may consider additional meetings or communication strategies. As an example, some HCCSS regions host Complex Care rounds as an opportunity for providers to discuss time-sensitive patient concerns in between clinic visits. In the Hamilton Niagara Haldimand Brant region, these rounds are organized as follows:

- Rounds are scheduled monthly by HCCSS admin via Zoom/MS teams and sent to the Complex Care team, as well as all children's CCs.
- 1 week prior to the call, CCs confirm which patients would benefit from being discussed that month. The admin then groups patients by CCs (if more than one patient belongs to 1 CC, they will go together) and confirms who needs to be on the call.
- At the time of the call, the manager opens and the first CC joins at onset. Patient and family is discussed.
- Once finished, the manager invites the next CC to join.
- Repeat.

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