Care Conference: Guidelines
Step 2 resource

**Agenda for Care Conferences:**

The Care Conference will be used to bring together the entire care team to:

1. Review/confirm/revise a Health Link Patient/Client’s Coordinated Care Plan
2. Identify any gaps in programs, supports and services required to implement the CCP.
3. Problem solve for better co-ordination of services to address any gaps in programs, supports or services;
4. Clarify roles of each team member, including the client and family/caregiver
5. Identify any other service providers who should be added to the care team going forward
6. Assign or re-assess the most capable and appropriate provider to serve as System Navigator

**Reasons for Scheduling a Care Conference?**

- Initial Care Conference to confirm/review CCP and Care Team Members
- Follow-up Care Conference (s) when deemed appropriate by System Navigator assigned to Patient/Client
- To support discharge planning;
- If client/caregiver is identified at risk and/or unsafe by any care team member;
- If a potential crisis situation has been identified by any care team member.

**Who Should Participate in the Care Conference?**

The need for a conference may be identified by:

- Provider who confirmed eligibility/referred Patient to Health Links and who has initiated the Coordinated Care Plan
- Provider who is currently designated as System Navigator for the Health Link Patient
- Any provider who has identified that the client/caregiver is at risk or unsafe or that there is a potential crisis situation.

All members of Patient/client’s care team should be included in the care conference. The Care Team includes the Patient/Client and their Family/Caregiver, as well as:

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<th>Care Team Members</th>
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<tr>
<td>Starting Point In-Hospital</td>
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<tr>
<td>Starting Point In Community</td>
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SMMH
PEFN, CCAC - TCC and CCC, SASOT, PC* + any other obvious providers (Mental Health, Housing, etc.)

Primary Care *
(FHT, NPLC, Health Hub)
CCAC – CCC (if eligible)
+ any other obvious providers (Mental Health, Housing, etc.)

HDMH
PEFN, CCAC – TCC and CCC, GCT, PC* + any other obvious providers (Mental Health, Housing, etc.)

*If not attached to Primary Care, then include primary care as priority goal in CCP

Scheduling of Conferences:

A conference should be scheduled within two weeks from the date of request. For clients at risk and/or unsafe, a conference should be scheduled as soon as possible.

Location:

The conference should be held where it is most appropriate for all participants:
- Patient’s Care Location or Client’s home;
- Primary Care Provider’s office;
- CCAC office;
- Another agency’s office.

Time Frame:

- Suggested time frame: approximately (30) min in length;
- Dependent on the number of participants and the number of issues to discuss.

Responsibilities:

The individual coordinating the Care Conference is responsible for:

Prior to the Conference:
- Verbally arranges date, place, start and finish time of conference with participants;
- Give reason(s) for conference and discusses with each participant the specific concern(s) to be addressed at the conference.

At the Conference:
- Act as the host of the care conference;
- Introduce all participants;
- Appoint note-taker;
- State summary of care to date and coordinated care plan;
- Ask the individual participants for verbal reports specific to the purpose of the conference;
- Facilitate group discussion/problem solving;
- Keep group on topic and focused on the purpose of the conference;
• Summarize final discussions including outcomes, actions to be taken and responsibility of whom;
• Establish method of feedback re implementation of plans (date and time of next conference may be scheduled if appropriate).

After the Conference:
• Send updated CCP and conference notes to all participants;
• Review service provider progress reports to ensure follow-up on action to be taken/outcome.