

## TITLE

**DOCUMENTING CARE COORDINATION**

## SCOPE

Provincial: Addiction &amp; Mental Health Ambulatory Settings

## DOCUMENT #

AMH-09-01

## APPROVAL AUTHORITY

Vice President, Provincial Clinical Excellence

## INITIAL EFFECTIVE DATE

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## SPONSOR

Executive Director, Addiction &amp; Mental Health

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Not applicable

## PARENT DOCUMENT TITLE, TYPE, AND NUMBER

Not applicable

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July 6, 2023

**NOTE:** The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

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**OBJECTIVES**

- To provide direction to Addiction & Mental Health (AMH) **health care providers** working in community/ambulatory settings when completing **clinical documentation / health records** for **patients** in their care.
- To support health care providers in completing consistent **care coordination** that shall include screening/assessment, treatment planning, care conferencing, progress notes, and file closure / discharge summaries.

**APPLICABILITY**

Compliance with this document is required by all Alberta Health Services employees, members of the medical and midwifery staffs, students, volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary).

**ELEMENTS****1. Care Coordination**

- 1.1 Standards for care coordination in ambulatory settings should be the same across the province to ensure consistency in expectations of how patients are to be treated and how their clinical information is recorded.

**2. Screening/Assessment**

- 2.1 Each patient shall be screened/assessed using standardized tools with a biological, psychological, social, and spiritual approach in partnership with the patient and **family**, as applicable, and documented in the health record.

### 3. Treatment Plan

- 3.1 Treatment plans shall be documented in the health record and based on screening/assessment, developed with the patient, built upon and be tailored to focus on the patient's strengths.
- 3.2 Treatment plans shall include:
- a) goals based on the needs, specific circumstances, abilities, beliefs, and priorities identified by the patient. Goals shall have clearly defined outcomes, and be specific, measurable, achievable, relevant, and timely;
    - (i) Health care providers shall work directly with patients and their families, as applicable, to create these goals. Patient autonomy shall be respected and supported throughout the process.
  - b) how goals/results will be monitored;
  - c) a description of the recommended treatment, including who will be involved and their roles in the treatment; and
  - d) the treatment timelines, frequency of visits, and expected duration of treatment.
- 3.3 Treatment plans may also include, as applicable:
- a) symptom management; and
  - b) a return-to-use prevention plan and/or crisis/**safety plan** using a **harm reduction approach**.
- 3.4 At the development of the treatment plan and upon any change to the treatment plan, the **most responsible health practitioner (MRHP)** shall ensure that:
- a) the treatment plan is reviewed with the patient;
  - b) the patient has been given the opportunity to ask questions and confirm their understanding of the treatment plan;
  - c) valid informed consent for the treatment plan has been obtained from the patient in accordance with the AHS *Consent to Treatment/Procedure(s)* Policy Suite; and
  - d) the patient, family, and other service providers, as appropriate, are provided with a copy of the treatment plan.
- 3.5 Copies of the treatment plan shall be provided to the patient, family, and other service providers in accordance with the *Health Information Act* (Alberta).

#### 4. Care Conference

- 4.1 Care conferencing is a routine and important clinical procedure where the health care team gathers at a pre-determined time to discuss selected patient circumstances and obtain feedback on the proposed treatment.
- 4.2 Care conferences shall utilize a **recovery-oriented** approach that builds on and is tailored to focus on a patient's strengths. This approach is intended to increase a patient's quality of life and the sense of control over their life.
- 4.3 Care conferences provide routine opportunities to:
- a) identify or clarify issues regarding a patient's health status, needs, and goals;
  - b) review patient progress and any barriers towards goals;
  - c) clarify roles and responsibilities;
  - d) resolve challenges or strategize solutions; and
  - e) adjust treatment plans when needed.
- 4.4 Care conferences should occur when:
- a) clinically indicated;
  - b) there is intensified risk;
  - c) current treatment progress differs from anticipated treatment progress;
  - d) patient circumstances are complex (i.e., drop-out potential);
  - e) multiple agencies are involved; and/or
  - f) they are requested.
- 4.5 Participants at care conferences may include the following:
- a) patient;
  - b) family member / support system;
  - c) supervisor;
  - d) Physicians / Psychiatrist / Nurse Practitioner;
  - e) health care providers;
  - f) support workers; and/or

g) community service providers.

4.6 The MRHP shall document the care conference in the health record to include:

- a) the purpose of the care conference;
- b) the names and roles of those in attendance; and
- c) decisions and treatment recommendations.

4.7 Upon completion of the care conference, any changes to the treatment plan shall be documented. A copy of the updated treatment plan shall be provided to the patient, family, and other service providers in accordance with the *Health Information Act* (Alberta).

## 5. Progress Notes

5.1 Progress notes should be used to record progress towards treatment goals, risk management, inform changes to the existing treatment plan, discharge summary, and/or indicate a need for a care conference.

5.2 Health care providers shall ensure that the progress note in the health record is reflective of treatment progress and shall include the following:

- a) date of contact;
- b) who was present;
- c) how and where contact was made;
- d) patient presentation (i.e., observed mental state);
- e) description of session (summary) and progress being made;
- f) any changes to patient situation (e.g., risk assessment); and
- g) next steps (e.g., date of next appointment).

## 6. Discharge Summary

6.1 Discharge summaries are a key component in transitions in care and shall include the following:

- a) an analysis of treatment:
  - (i) a summary of discussion regarding goals, outcomes, and progress;

- b) a transition plan:
    - (i) risk assessment to determine level of support needed post-discharge (e.g., suicide risk screen); and
    - (ii) decisions regarding after care (i.e., follow-up/transition options, community service navigation);
  - c) closure summary documentation:
    - (i) the date and reason for file closure; and
    - (ii) the effectiveness of interventions.
- 6.2 A copy of the discharge summary shall be provided to the patient, family, and other service providers in accordance with the *Health Information Act* (Alberta).

## 7. Documentation

- 7.1 Documentation is vital to the provision of high quality health services. The health record is a critical component of collaborative care, patient and family-focused service, and quality assurance.
- 7.2 The MRHP shall document the patient's informed consent in accordance with the *AHS Consent to Treatment/Procedure(s) Policy Suite*.
- 7.3 The patient's consent for disclosure of information shall be discussed and documented, in accordance with the *AHS Collection, Access, Use and Disclosure of Information Policy*.
- 7.4 When documenting in the patient health record, health care providers shall adhere to the *AHS Clinical Documentation Directive, Clinical Documentation Process Directive, Reporting of Clinical Adverse Events, Close Calls and Hazards Procedure* and the *Health Information Act* (Alberta).

## 8. Compliance Monitoring

- 8.1 AMH ambulatory settings are required to adhere to AHS auditing expectations as developed by site/program processes in line with the *AHS Clinical Documentation Directive*.

## DEFINITIONS

**Care coordination** means a collaborative process of assessment, planning, facilitation, evaluation and advocacy focusing on achieving wellness while promoting self-management to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, and quality of care.

**Clinical documentation** means the process by which health information is captured in electronic or written format on the clinical record to reflect patient care and to facilitate

communication between providers. Clinical documentation also fulfills regulatory, legal, and Alberta Health Services requirements regarding status, care, and services provided to patients.

**Family(-ies)** means one or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the health care system, including but not limited to, family members, legal guardians, friends, and informal caregivers.

**Harm reduction approach** means acceptance that abstinence may or may not be a realistic or desirable goal for an individual patient, and explicitly acknowledges that the cessation of substance use is not a prerequisite for accessing health or social services. Interventions may be targeted at the individual, the family, community or society.

**Health care provider** means any person who provides goods or services to a patient, inclusive of health care professionals, staff, students, volunteers and other persons acting on behalf of or in conjunction with Alberta Health Services.

**Health record** means the collection of all records documenting individually identifying health information in relation to a single person.

**Most responsible health practitioner (MRHP)** means the health practitioner who has responsibility and accountability for the specific treatment/procedure(s) provided to a patient and who is authorized by AHS to perform the duties required to fulfill the delivery of such a treatment/procedure(s) within the scope of their practice.

**Patient** means all persons, inclusive of residents and clients, who receive or have requested health care or services from Alberta Health Services and its health care providers. Patient also means, where applicable:

- a) a co-decision-maker with the person; or
- b) an alternate decision-maker on behalf of the person.

**Recovery-oriented** means encompassing a broad construct that is person-centred and promotes resilience. Clinicians work in partnership with individuals and their families to build on personal strengths and skills to enhance health outcomes and quality of life.

**Safety plan** means a plan developed with the patient and is usually summarized as a written plan for the management of increased danger of suicide or self-harm and how to stay safe.

## REFERENCES

- Alberta Health Services Governance Documents:
  - *Clinical Documentation Directive* (#1173)
  - *Clinical Documentation Process Directive* (#1173-01)
  - *Collection, Access, Use and Disclosure of Information Policy* (#1112)
  - *Consent to Treatment/Procedure(s) Policy Suite* (#PRR-01)
  - *Harm Reduction for Psychoactive Substance Use Policy* (#HCS-33)
  - *Reporting of Clinical Adverse Events, Close Calls and Hazards Procedure* (#PS-95-04)
- Non-Alberta Health Services Documents:
  - *Health Information Act* (Alberta)
  - *Report of the Auditor General* (2015)

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