

## **Integrated Community Lead (ICL): Tool Kit**

The ICL Model is an “approach” to providing services where a community service provider supports the client through identification and connection to services they want and need, coordinating those services, making the client aware of who to call when they require help, and supporting the client through transitions. This Tool Kit has been adapted from pre-existing BSO documentation and framework.

This Tool Kit includes information about the ICL Model and how this group may implement the model. Information in this tool kit comes from multiple sources including Behavioural Supports Ontario, HealthLink HNHB, as well as input from the working group.

### **Why the ICL model**

- Improved experiences with transitions between care settings and within the broader system
- Improved access for clients and caregivers to relevant and effective services and supports in a timely fashion
- Reduction in duplication for services and assessments from participating agencies
- The client's needs and wants are central to the Plan of Care
- Improved collaboration and coordination leads to improved outcomes and avoidance of emergency department visits/hospitalizations

### **Who should use this Tool Kit**

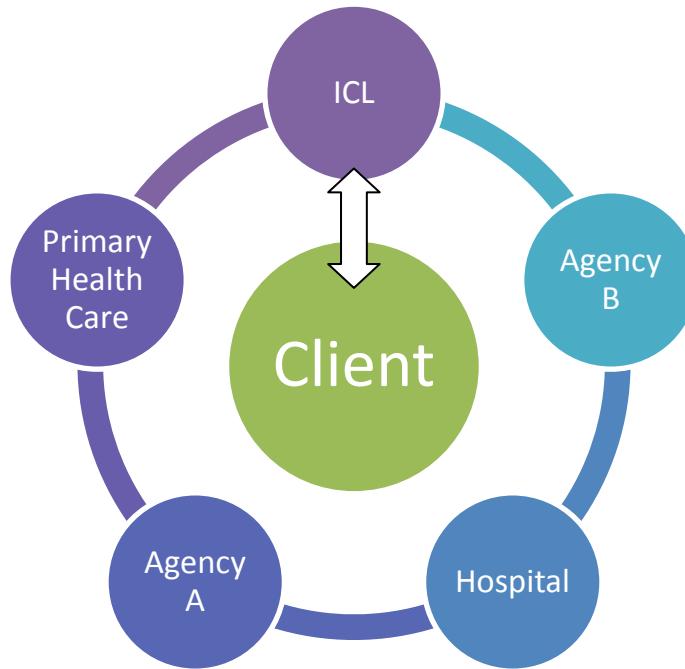
This tool can be adapted by any community agency front line staff wanting to change the way we connect with our clients and with community partners. It is for anyone wanting to help clients from cycling through Niagara's services to providing longer term community supports and client centered care.

### **Purpose of the Tool Kit**

To provide core knowledge of the ICL Model and how to implement its principles. This includes: identifying the ICL 'Lead' and the Lead's role, ensuring client centered care, obtaining release of information, connecting with community partners, developing a community-wide plan or care, and how to evaluate the ICL Model at your agency.

## **What is the ICL Model**

ICL is an approach to care where one Lead navigates the system for the client in collaboration with health care providers and other agencies.



### **ICL Client Population:**

People with mental health and addictions issues frequenting the emergency department and/or reliant on crisis services (e.g. COAST, MCRRT)

### **The ICL Lead**

An agency that has been identified as the lead agency for a client is considered the ICL or “Lead”. The Lead is responsible for coordinating the care for a client. Criteria for identifying a Lead includes: a) the agency with the most significant experience with the client in addressing their care needs, b) the client’s preference for their Lead based on comfort, history, relationship or other factors, c) the agency that can provide services that meet the client’s care needs.

The Lead must have:

- A strong understanding of the client's priority needs and is able to identify which community agencies can help address these needs
- A good rapport with client and is able to connect with the client in a timely manner
- A strong understanding of client consent and sharing of information
- A strong understanding of client-centred care

The Lead's Roles and Responsibilities:

- Obtaining existing information from the client of previously received services
- Conduct initial assessment of the client's situation, including exploring the client's unmet needs
- Minimizing/managing the risk across the gap from time of referral to the time the client receives services
- Ensuring the client understands privacy and consent, and that consent may extend to other agencies services as care plan evolves, and that they may rescind their consent at any time

The Lead will determine if the client may require further support from other agencies or services as appropriate. If additional supports is deemed appropriate the Lead contacts other agencies to develop a working collaborative with a focus on developing and coordinating a Plan of Care. The Lead is responsible in monitoring the progress of the care plan.

#### *Change in Lead Person/Agency*

The ICL- person / Agency may transition to another person or agency depending on: where the client is in their Plan of Care, if the client is more appropriate for another ICL, if the client requests a change in ICL. When transition from one lead to another, it is important to ensure: everyone, including the client, is aware of their role, the previously Lead shares relevant information to the new Lead, and the client is fully supported through the transition.

#### **How to 'Lead' – Coordination and Collaboration**

The Lead should ensure the following steps have taken place:

- Set goals and prioritize services to meet the client's needs within the agencies services
- Determine if additional supports are needed and therefore: make 'active referrals', develop a working relationships with other agencies, bring agencies together where clients are complex or in challenging situations, collaborate on a Plan of Care
- Emphasize the importance of stress reduction for the client
- Engage Primary Care through: communication of assessment findings and plan, regular updates on status of client, encourage client to visit primary care provider routinely
- Build a relationship with client and foster realistic expectations for current and future care
- Review with client their crisis plan if they have one. If the client doesn't have one, consider working with the client and identify partners in creating one

## **Plan of Care Development**

There may be times through the initial assessment that The Integrated Community Lead Model calls for the Lead to develop a Plan of Care with the client and all of their service providers as soon as possible after commencing service.

The Plan of Care identifies the date of the meeting, a unique identifier for the client, the name of the Lead and contact information for the Lead.

During the meeting the Plan of Care will be established. It will include: the client's goals, the plan, the action, the person or agency responsible and the time frame for service. (See Appendix A for Plan of Care Template)

The Lead will be responsible for holding and updating the Plan of Care as the client or other service providers notify of changes. Changes to the Plan of Care will be shared in the format agreed upon by the client and other service providers.

With the client's consent, a brief summary of the Plan of Care will be added to the client's Safety Plan (see Appendix B for Safety Plan) as this will help crisis responders to be aware of who is involved in the client's care and what services are currently being offered. The Safety Plan is faxed to both COAST and PERT, and should be updated as required with updates being forwarded to COAST and PERT.

## **Consent and Sharing of Information**

The Integrated Community Lead Model requires the client to be an active participant in their Plan of Care.

Clients **must** be informed of their privacy rights prior to engaging this model (see Appendix C for Privacy Rights).

The ICL Model requires consent of the client to collect and to share information between Service Providers. Use the consent form as per your agency's policies.

For information regarding when personal health information can be shared amongst Health Service Providers – Circle of Care (see Appendix D)

Communication with the client and other service providers with regard to the Plan of Care, or changes to it is primarily the responsibility of the "Lead."

It is important to note that the client may withdraw consent for the sharing of information at any time.

The client must have capacity to provide consent. If the individual has been deemed incapable, then consent must be obtained by a Substitute Decision Maker or Legal Guardian before you can proceed.

Finally, any personal health information being stored by any service provider, must follow legislative requirements.

***(NOTE: This information does not override the policies of your organization. If you are unsure of your organization's policies on consent, please consult your organization's Policies and Procedures Manual or the Privacy Officer.)***

## Appendix A

## Plan of Care Template

**Date of Meeting:**

**Unique Identifier:**

**Lead:**

**Phone Number:**

**Attendees:**

Goals	Plan	Action	Person/ Agency Responsible	Timeline

Please add a brief summary of this Plan of Care to Client's Safety Plan

Client consent to share Plan of Care and changes to plan: YES / NO

If Yes, then: agreed upon method of sharing: In Person Only / Phone / Email with unique identifier

Contact Information for Care Team:

Name:                          Phone Number:                          Email Address:

## Appendix B

# SAFETY PLAN

### Niagara Crisis Prevention Protocol

Date:	DOB:
Name:	Emergency Contact/Substitute Decision Maker/Guardian: (name and number below)
Address:	
Client Tel #:	Contact #:
Psychiatrist:	Contact #:
Family Physician:	Contact #:
Integrated Community Lead:	Contact #:
Known Diagnoses (medical and psychiatric):	Contact to collect Medication History: <b>*Be sure to bring current MAR to ER</b>

List Stressors or Triggers:

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What would you NOT find helpful during a crisis?

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#### LEVEL 1 (BEGINNING ESCALATION PHASE or STRESS PHASE/Early Warning Signs)

What do you feel when you are stressed?	What helps at this time?

**LEVEL 2 (PRE-CRISIS or DISTRESS PHASE)**

<b>When you are feeling overwhelmed what might we see? (emotional/physical)</b>	<b>What helps at this time?</b>

**LEVEL 3 Crisis Phase**

<b>How do you know when you are in crisis and need help? What do you feel and do?</b>	<b>What helps at this time?</b>

**Who should we notify when you are in crisis?****Summary of Plan of Care:**

<b>Agency Involved</b>	<b>Service Provided</b>

<b>I agree with this Safety Plan:</b>	<b>Valid until:</b>
<b>Client/Guardian:</b>	<b>Date:</b>
<b>Witness:</b>	

**Date of next review:**

**CONSENT FOR THE COLLECTON, USE AND**  
**DISCLOSURE OF PERSONAL HEALTH INFORMATION**

- 1. I have had all my questions answered to my satisfaction and fully understand that specific providers will either collect, use and/or disclose my personal health information.**
- 2. I have been advised and I am aware that the following providers will collect, use and/or disclose my personal health information.**
- 3. I have initialed the specific boxes to indicate my consent with respect to the collection, use and/or disclosure of my personal health information.**

Crisis Outreach and Support Team (COAST) – Distress Centre	
Psychiatric Emergency Response Team (PERT) – Niagara Health System	

I have been advised and I understand that I can withdraw my consent to the collection, use and/or disclosure of my personal health information at any time by contacting  
my primary service provider or **COAST at 1-866-550-5205 (Press "1")**

**THEREFORE, HAVING REVIEWED AND FULLY UNDERSTANDING THE PURPOSE OF THIS CONSENT,** I consent to the collection, use and disclosure of my personal health information to the specific providers indicated above.

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Printed Client Name

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Signature

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Substitute Decision Maker, if applicable

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Signature

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(Date (ddmmyyyy))

# The Personal Health Information Protection Act and Your Privacy



Information and Privacy  
Commissioner/Ontario

Ann Cavoukian, Ph.D.  
Commissioner

## Introduction

The *Personal Health Information Protection Act, 2004* is a new provincial law that governs the collection, use and disclosure of personal health information within the health care system. The object is to keep personal health information confidential and secure, while allowing for the effective delivery of health care services.

Under this legislation, health care providers and others who deliver health care services are collectively known as health information “custodians.”

### *What is personal health information?*

Personal health information includes any identifying information about an individual's health or health care history, such as your family medical history, details of a recent visit to your doctor, or your Ontario health card number.

### *Do health information custodians need my permission to access my personal health information?*

Custodians are permitted to collect, use and disclose your personal health information, on the basis of implied consent, for the purpose of providing your health care.

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An example where implied consent would be sufficient is if a family physician refers you to a medical specialist for consultation or to a laboratory for testing and discloses your personal health information for that purpose.

### *Can I prevent health information custodians from collecting, using or disclosing my personal health information?*

Yes. You have the right to withdraw your consent at any time.

In addition, custodians must respond to inquiries and complaints about the personal health information they hold about you.

The information practices of custodians must be available in written form, as well as information on how to contact them.

### *As a patient, do I have the right to see my personal health information?*

Yes. You have a right to access your health information records under the new law. You may be asked to make the request in writing, and custodians are allowed, depending on the circumstances, 30 to 60 days to respond to your request. You may be charged a reasonable fee to cover the costs.

2

Certain limited exceptions to access exist, but where custodians deny access to your records, they must explain the grounds for doing so, and you have the right to complain about denials or other access decisions to the Office of the Information and Privacy Commissioner/ Ontario (IPC) within six months of the decision.

#### *What if the personal health information filed about me is inaccurate or incorrect?*

You can request that your health information be corrected. However, health information custodians may require that you make the correction request in writing and, depending on the circumstances, they are given 30 to 60 days to respond.

Custodians are not required to correct professional *opinions*, however, you may require that a statement of disagreement be attached to your health records, and that your disagreement be communicated to others involved in your treatment and care.

Where a correction is refused, custodians must give reasons. You can then complain about a refusal to correct your health information to the IPC (within six months of the decision).

3

#### *What do I do if I have a complaint?*

Complaints about the actions of health care providers in their handling of your personal health information can be filed with the IPC. These include the improper collection, use or disclosure of your personal health information. Complaints should be filed within one year of you becoming aware of a problem.

The IPC will attempt to mediate your complaint to resolve the dispute wherever possible. Otherwise, the IPC may issue an order.

#### **About the Commissioner**

The Information and Privacy Commissioner, Dr. Ann Cavoukian, is appointed by the Ontario Legislature and is independent of the government of the day. She was recently re-appointed for a second term.

There is extensive information about the *Personal Health Information Protection Act, 2004*, including Frequently Asked Questions, and a user *Guide* for health information custodians, on the IPC website: [www.ipc.on.ca](http://www.ipc.on.ca).

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*For more information about any of these Acts or the role of the IPC, please call, write or email:*

Information and Privacy  
Commissioner/Ontario  
2 Bloor Street East, Suite 1400  
Toronto, Ontario M4W 1A8  
Telephone: (416) 326-3333  
or 1-800-387-0073  
Fax: (416) 325-9195  
TTY: (416) 325-7539  
Website: [www.ipc.on.ca](http://www.ipc.on.ca)  
Email address: [info@ipc.on.ca](mailto:info@ipc.on.ca)



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TTY (Teletypewriter): 416-325-7539  
Website: [www.ipc.on.ca](http://www.ipc.on.ca)

## Appendix D

### Health Service



**CIRCLE OF CARE**

SHARING PERSONAL HEALTH INFORMATION  
FOR HEALTH-CARE PURPOSES

**iP** Ann Cavoukian, Ph.D.  
Information and Privacy Commissioner,  
Ontario, Canada