# PS.CM Map 8.01: High Intensity Supports Wait At Home Business Process

Legend: ALC=Alternate Level of Care, CC=Care Coordinator, CCP= Coordinated Care Plan, CE LHIN=Central East LHIN, CSS=Community Support Services, HCC=Home and Community Care, HISH=High Intensity Supports Wait At Home Program, HSSIPP=Health System Strategy, Integration, Planning and Performance, NP=Nurse Practitioner, POA-H CC=Point of Access Hospital Care Coordinator, SPO=Service Provider Organization, TA=Team Assistant

## PoA Hospital CC

- Identifies patient in hospital that may meet eligibility for HISH
- Completes InterRAI using eligibility criteria to determine patient is eligible for the HISH program
  Contacts HISH CSS
- Arranges HISH Case Conference for patient
  Invites HISH NP, HISH SPO and HISH CSS agency for a HISH Case Conference one (1) week prior to date of discharge
- Discharge Plan is determined based on patient needs
  Sends HPG for HISH pathway to HISH SPO
  Completes CSS service offer with new authorized plan
- Advises patient HISH Care Coordinator is their new point of contact
  Provides HISH CC contact information
- Connects with HISH CC to advise of admission to HISH caseload

  Patient discharged to Community

## Community CC

- Identifies existing patients in their caseload that may meet eligibility for HISH
- Completes InterRAI using eligibility criteria to determine patient is eligible for the HISH program
- Case reviewed and approved by Senior Manager
  Contacts patient to notify them that HISH Care Coordinator is their new point of contact
  Provides HISH CC contact information
- Connects with HISH CC to advise of admission to HISH caseload and for the geographical region to collaborate on service planning and next steps
- Arranges HISH Case Conference in collaboration with HISH CC
  Contacts HISH CSS
- Sends HPG for HISH pathway to HISH SPO
  Completes CSS service offer with new authorized plan
- Transfers patient to HISH caseload

## HISH Community CC/HISH TA

- **HISH CC**
  Receives task for admission to HISH caseload
- **HISH CC**
  Contacts patient within 24 business hours to review care plan and or initiates Coordinated Care Plan
  Contacts HISH CSS

  Sends referral to Community Paramedicine (if required)

  Tasks HISH TA to set Microsoft Teams HISH Case Conference
- **HISH TA**
  Reaches out to HISH NP, HISH SPO contact, HISH CSS contact and Community Paramedicine contact (if required)
  Sets up Microsoft Teams HISH Case Conference within 5-7 business days

  *Note: if appropriate, patient/family/ caregiver also invited to attend*
- **HISH CC**

  Documents/updates in CHRIS

  Updates HISH pathway in CHRIS
- **HISH CC**
  Completes patient assessment within 7 business days as per normal process

  Updates the HISH Care Team if there are any changes from the assessment
- **HISH CC**
  Monitors patient status in community ongoing, utilizing the monitoring app (when available)
  Continues to collaborate with HISH SPO, NP, CSS and Paramedicine regarding patient status
  Arranges additional HISH Case Conferences as needed

**Note:** Coordinated care plan to be recommended at each touch base with patient. If patient authorizes a CCP follow *PS.CCP Map 1.02 Coordinated care planning-Initial/ New* for implemeation

## Dedicated HISH SPO/HISH CSS

- Receives invite to HISH Case Conference
  CSS receives call from PoA/ Community/HISH CC
- Attends HISH Case Conference

  Enacts agreed upon service plan

  Collaborates and integrates an action plan to meet patient needs
- Receives CSS referral/HISH pathway

  Completes patient visit(s) as per CSS referral/HISH pathway
- Reporting structure TBD
- Continues to collaborate with HISH Care Team regarding patient status
  Updates care plan
  Attends additional HISH Case Conferences as needed

## Community Paramedicine Services

- Receives new patient referral from HISH CC
- Attends HISH Case Conference
  Collaborates and integrates an action plan to meet patient needs
- Completes patient visit(s) as per agreed service plan determined at HISH Case Conference
- Sends LHIN Funding Performance Report to CESubmissions@lhins.on.ca
  Patient Report structure TBD
- Continues to collaborate with HISH Care Team regarding patient status
  Updates care plan
  Attends additional HISH Case Conferences as needed

## CE LHIN HISH NP

- Receives invite and attends HISH Case Conference
  Provides clinical support
- Receives task from HISH CC identifying patient discharged from hospital; continues to provide clinical support and medical oversight to patient upon discharge to Community
- Collaborates and integrates an action plan to meet patient needs
- Completes face to face clinical assessment with patient
  Determines ongoing care plan to meet patient needs
  Notifies HISH CC of visit plan
- Continues to collaborate with HISH Care Team regarding patient status
  Updates care plan
  Attends additional HISH Case Conferences as needed