Step By Step Guide To Coordinated Care Planning

Step 1 - Identification / Referral
- Client is identified as a high user or at risk of being a high user
- Use criteria check list to confirm health link eligibility and obtain Client consent
- Notify Health Link PM of Patient Identification for referral and tracking

Step 2 - Assess Client Goals, Needs and Care Team Members
- Host Care Conference with Client and Care Team members (30 min.):
  - Confirm/revise the draft CCP
  - Identify additional Care Team members to be added to the team based on needs
  - Identify and assign most appropriate and capable Provider to be System Navigator
  - Notify Health Link PM of System Navigator

Step 3 - Care Conference
- Fulfill role of System Navigator and support Client to execute care plan
- Serve as liaison to the Client and family
- Monitor progress and communicate to Care Team members

Step 4 - System Navigation
- System navigator hosts follow-up care conference in 1-6 weeks (depending on patient needs) to assess what’s working, not working.
- Refresh CCP where appropriate and re-evaluate most appropriate and capable system navigator
- Notify Health Link PM of System Navigator if changed

Step 5 - Follow Up Care Conference (s)
- Continue to fulfill role of system navigator
- Call additional Case Conferences if/when necessary
- Contact HL project Manager to trigger Client Satisfaction Survey (Third Party Evaluator)
- Prepare patient to graduate from Health Links if appropriate

ON-GOING System Navigation

Health Link Project Management Functions/Role:
- Referrals (where required)
- Client, Navigator and CCP Tracking
- Coordination Client Satisfaction

<table>
<thead>
<tr>
<th>Care Team Members</th>
<th>Starting Point In-Hospital</th>
<th>Starting Point In Community</th>
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<tbody>
<tr>
<td>SMMH</td>
<td>PEFN, CCAC - TCC and CCC, SASOT, PC* + any other obvious providers (Mental Health, Housing, etc.)</td>
<td>Primary Care * (FHT, NPLC, Health Hub) CCAC – CCC (if eligible) + any other obvious providers (Mental Health, Housing, etc.)</td>
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<tr>
<td>HDMM</td>
<td>PEFN, CCAC – TCC and CCC, GCT, PC* + any other obvious providers (Mental Health, Housing, etc.)</td>
<td>*If not attached to Primary Care, then include primary care as priority goal in CCP</td>
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