HealthLink

COLLABORATIVE CARE CHECK LIST

Phase	Activity	Who	Task Complete
Day 1			
Identification	Currently Primary Care Referral based on high user of ER or hospital Or Transitional Care Team From Hospital	Primary Care	
Referral	Refer patient name to Health Link – hls on EMR reaches Anne-Marie	Primary Care	
	Review patient information to determine correct system navigator (most responsible provider)	HL Coor – through EMR	
	Refer patient name / patient id to system navigator – through EMR Initiation of CCP in EMR	HL Coor	
Week 1			
Engagement	Contact patient and family to explain Health Link	System Navigator or Primary Care Provider	
	Arrange date for patient/family in home Interview and include Primary Care provider if possible	System Navigator w Primary Care	
	Forward date to Health Link coordinator	System Navigator to HLC	
	Conduct the interview – Explain and obtain consent – Illicit signature on consent form Book Think Tank call with HL Coordinator	System Navigator and Primary Care	
Week 2			
Engagement	Attend Think Tank Call – Explain the patient story to the Think Tank – Brainstorming session	Navigator – Think Tank Team	
	Provide list of suggestions made to the system navigator – "next steps" form	HL Coordinator	
Investigation/ Assessment	Begin investigating the health and community services suggested – create a plan to be shared with patient	Navigator (supported by 211 and HL Coordinator as needed)	
A: Collaboration when simply augmenting to existing Care Plan	**A:** Contact Patient by phone or in person to review and confirm their desire/approval to move forward with agencies/services/providers or programs	Navigator	
B: Collaboration Care Conferencing ** **when introducing 2 or more services for a patient**	**B:** Contact Patient by phone or in person to review and confirm approval to move forward with suggested care plan – services/programs. Find a convenient time to have the group meet with patient and family	Navigator / Patient	
	Begin to set up Care Conference with the Primary Care / providers Set date, time, how they will attend (in-person/via OTN/teleconference) Provide background on Patient Goals	Navigator	
	Begin working on Health Link – Coordinated Care Plan in EMR to bring to Care Conference – Plan will be completed after the conference	Navigator, Primary Care, Services, Providers	

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Phase	Activity	Who	Task Complete
Week 3			
A: Collaboration when simply augmenting to existing Care Plan	Review suggested Care Plan with Primary Care Implement services or provide information on programs with assistance of other agencies and organizations. Where possible ensure a warm transfer or personal introduction of patient and caregiver to service provider.	Navigator / Primary Care / Service Provider	
B: Collaboration Care Conferencing	CARE CONFERENCE - ONE HOUR MAXIMUM Ideally in-person, but assisted by technology where this is not achievable - OTN - Identify alternatives for services that are wait-listed, including creative use of volunteer services through Home for Life to assist during the wait-time - Initiate access to selected services through Home for Life to assist during the wait-time - Initiate access to selected services	All Service Providers – facilitated by Navigator (HL coordinator if requested)	
Ongoing			
Patient Care Journal and Coordinated Care Plan	Review Initial Patient Care Journal with patient and caregiver – Ensure understanding of the details of their Care Plan ie # of Physio visits/dates/names and phone numbers – this is a leave behind form for patient and family use Complete Coordinated Care Plan – in EMR – to be completed after Care Conference – this piece allows all Primary Care and other service providers to understand the current Plan in place. This is an ongoing form requiring updates periodically Service Providers will message updates through Portal CCP – needs to be updated as programs are completed or when any change in care occurs – achieved through Portal Ensure Health Link Coor has signed consent form. Update via "next Steps" form on changes / services implemented	System Navigator – reviewed by Primary Care Navigator Health and Community Service Providers Navigator	
Follow up	Navigator and patient agree on a follow up plan. Usually 1 week follow up calls until Patient comfortable with Care Plan and schedule and/or patient has stabilized Continued updates to Primary Care through Portal / EMR	System Navigator Navigator / Primary Care	
	Update Care Plan Journal in home and any new information in the Coordinated Care Plan in the EMR	Navigator and Providers	
4-6 weeks from start of Care Plan			
Evaluation	4 – 6 week in home visit and interviewed required Results posted on CCP Or Survey dropped off at patient's house to fill out at their convenience	Navigator supported by Health Link Coordinated if required	