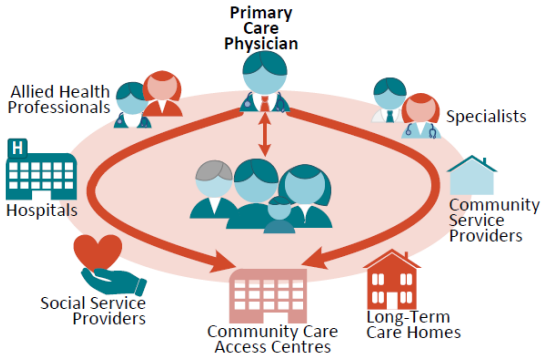
HealthLinks

Ontario
South West Local Health Integration Network

Coordinated Care Planning – Information for Health and Social Services Providers

What is Coordinated Care Planning?

Multiple providers, appointments and complex care issues can make it difficult to meet an individual's unique needs. A more collaborative approach to providing care can be achieved through a process called "Coordinated Care Planning". This process is about bringing multiple providers together, with the individual and his/her informal supports, to collectively understand the goals of the individual and develop a care plan to best support him/her. To ensure that each person benefits from evidence-informed, patient-centred goal setting and care planning, the Ministry of Health and Long Term Care (MOHLTC) has developed a standardized, Coordinated Care Plan template/tool.



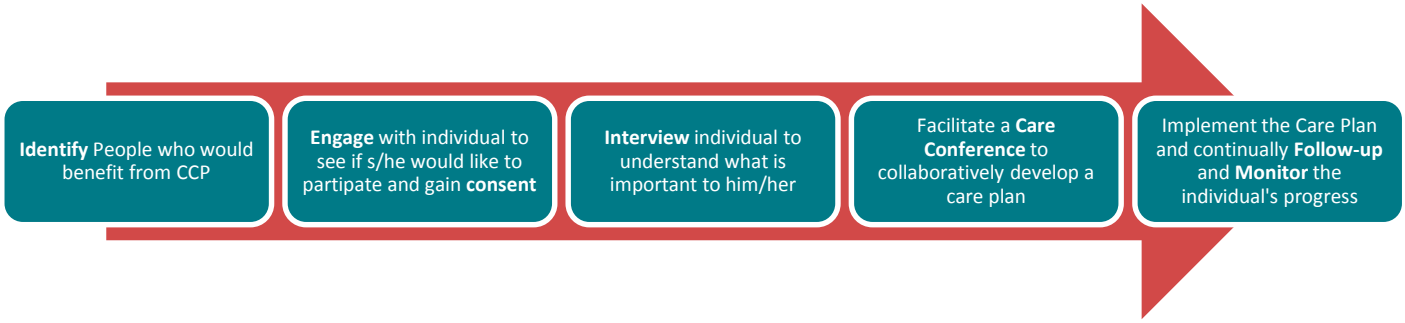
Who would benefit from a Coordinated Care Plan (CCP)?

Think about **people who would benefit most from coordinated support** from multiple health and social service providers; those with **high care needs** who would be best supported with a team approach, as outlined by the following table.

Target Population	People living with **4 or more chronic and/or high cost conditions**		
Identified Sub-Groups	Those with **Mental Health and Addictions** Challenges	**Palliative Population**	**Frail Elderly Population**
Considerations	Consider the following: • Economic characteristics (e.g. low income, unemployment) • Social determinants (e.g. challenges with housing, social isolation, language) • **4+ Emergency Department** (ED) visits AND **3+ Hospital Admissions** in the past year • **5+ ED Visits** in the past year		

What is the process for Coordinated Care Planning?

Once an individual is **identified,** and consent is obtained to participate in a CCP, a Lead Navigator/Care Coordinator is determined. The Lead is considered the single point of contact for the care team and is responsible for regularly updating the team. The Lead and the individual initially meet face to face to establish the individual's care needs, any relevant social determinants of health, and his/her care goals. They also work together to identify existing care partners and anyone who should be included in creating a care plan, including informal supports (e.g. family, spiritual support). The Lead then coordinates a **care conference** with the team and individual present to develop the care plan and begin the journey toward better care. Over time, care needs and goals may change; the care team will continue to **monitor progress** and adjust the care plan as required.

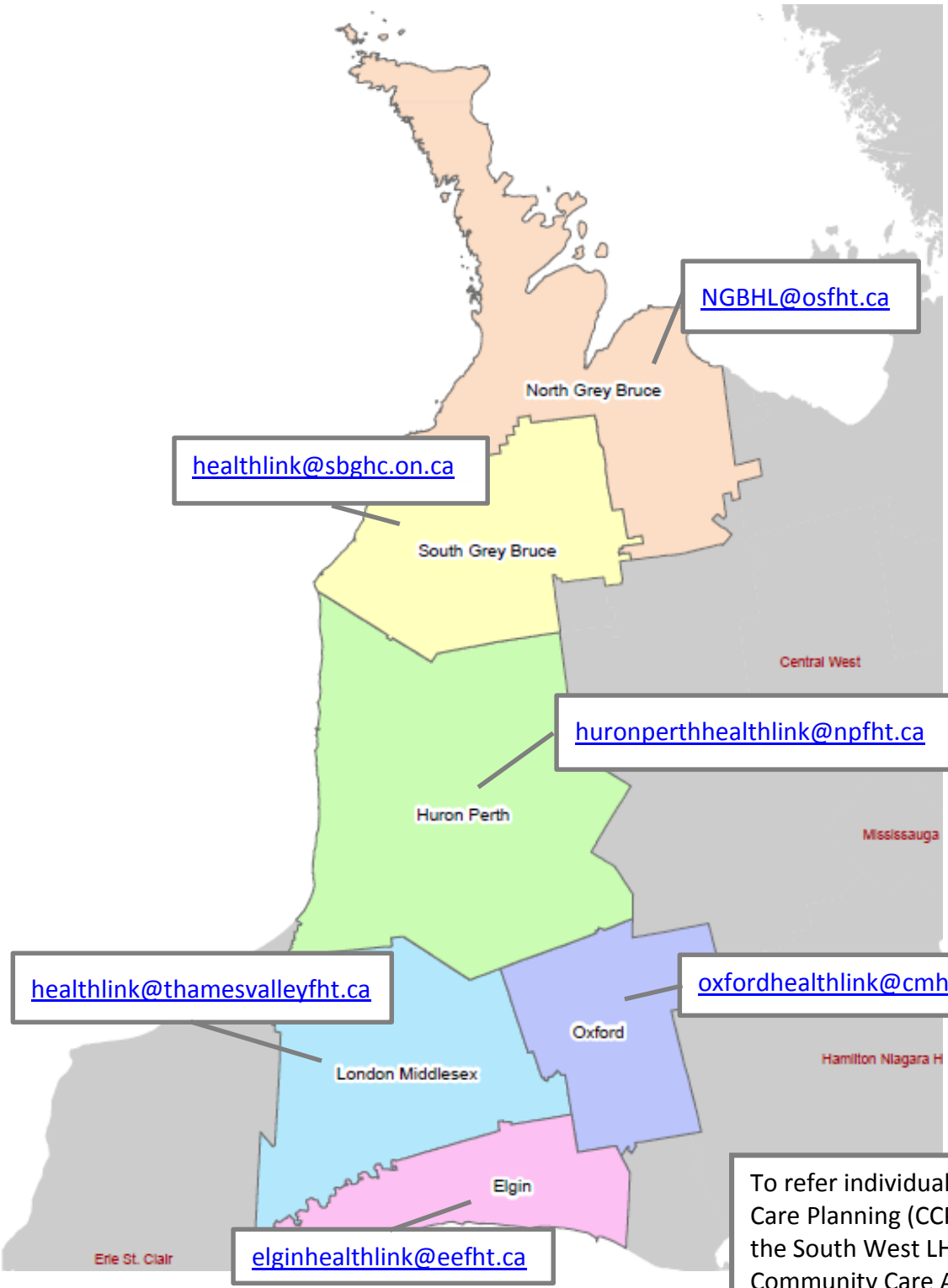


Supported by partnering organizations from Huron Perth, London-Middlesex, South Grey Bruce, North Grey Bruce, Oxford, and Elgin
Last updated: April 27, 2016

HealthLinks

Ontario
South West Local Health Integration Network

Who can I Contact for More Information?



To refer individuals for Coordinated Care Planning (CCP) anywhere across the South West LHIN, contact the Community Care Access Centre (CCAC):

- **Go to: http://ow.ly/Z2oSx**

or

- **Call 1-800-811-5146**