CARE COMPASS NETWORK

Title: Transition from Navigation Process
Date Created: 06/15/2016
Date Modified: 08/09/2016
Date Approved by Board of Directors: 08/09/2016
Clinical Guideline #CGC-CG- 22

Project 2ci: Community Based Navigation aims to provide community-based health navigation service to assist patients to access healthcare efficiently. Community Health Advocates guide patients through the healthcare system by eliminating barriers to timely access to healthcare services. Barriers to accessing care include financial, logistical, clinical, cultural and blending the communities between healthcare systems and community based organizations. Guidance can be through phone calls, in person, or web-based. Responsibilities of the Navigator differ between Type One Community Health Advocates and Service Type Two Community Health Advocates.

There are two purposes of this document to define a transition from navigation process. The first being to define low, medium, and high cases using current guidelines from: Crisis Stabilization, Integration of Behavioral Health in the Primary Care Setting, Disease Management, Care Transitions and Social Determinants. The second purpose is to give examples of what constitutes a successful navigation process with the caller/client/patient in the community setting.

Steps:

- Provide caseloads and discharge processes established for health navigators following patients longitudinally
- Determine what constitutes a 'graduation from navigation program' to identify patients by status/buckets
- Develop discharge processes for patients who receive navigation services. Triggers for discharge, proper follow-up post-discharge, and other methodological considerations will be borrowed from existing discharge processes, synthesized with current and future needs, and/or created anew.

Definition of Transition from Navigation:

Per Care Compass Network (CCN) 2ci Project Team, the term 'Graduation' and 'Discharge' from the navigation project will not be used or defined and changed to 'transition'. The project team defines 'transition' as the navigator working with the patient longitudinally to help reduce or eliminate their barriers to access care with the overall goal being that the caller/client/patient was successfully navigated to the appropriate resources in the community, and guided into a medical health home system.

Levels of Acuity Definition:

Per CCN 2ci Project Team, the navigator would determine the level of acuity based on intake and needs assessment. The intake and needs assessment would be a combination of social determinants and medical/ clinical needs the patient/client/caller is presenting with. The definition of 'Low', 'Medium' and 'High' for patient who receives community- based navigation services are as follows:

LOW: Immediate needs are able to be met through Type One Navigation using Community Resource Guide.
MEDIUM: More than one barrier is determined based on intake and needs assessment with client/caller/patient. Case management is needed with the patient/client to address those barriers. This is through Type Two navigation.
HIGH: Barriers are determined that are 'Triggers to the ED' and need immediate intervention. This is also through Type Two navigation.

The clinical/medical triggers to the ED will synthesize with current guidelines from the following*:

- *2. b iv 9 Guidelines for 30 Day Care Transitions (CGC-CG-01)*
- *2. b.iv Care Transition Protocol - 4 Pillars for Coordinated Care (CGC-CG-02)*
- *3. a.i. Integrated Primary Care and Behavioral Health-- Requirements for BH Screening Tools (CGC-CG-10)*
- *4. a. iii. Integrated Primary Care and Behavioral Health-- PHQ-9 Treatment and Follow Up Guideline (CGC-CG-05)*
- *3 g.i Palliative Care Triggers (CGC-CG-09)*
- *3 a.i Integrated Primary Care and Behavioral Health-- Medication Management Guidelines (CGC-CG-23)*
- *3. b.i Chronic Disease Self-Management Program Guidelines (CGC-CG-13)*
- *3. a. ii Definition of Crisis Stabilization Services, BH Crisis, and Community Wide Treatment Protocol (CGC-CG-16)*
- *A Conceptual Framework For Action on the Social Determinants of Health (World Health Organization)*

*Per 2ci Project Team, the Community–Based organization is expected to follow the guidelines stated above.

Definition of Success in Navigation:
Per Care Compass Network (CCN) 2ci Project team, success in Community-Based Navigation cannot be defined in one specific way, but will be defined on the overall outcome of patients engaging with the referral source(s) and receiving the needed intervention(s) to meet the identified need(s).

When PPS clinical protocols and pathways are developed through the Clinical Governance Committee(s) of the PPS and approved by the CCN Board of Directors and are applicable to Partner Organization's delivery of health care services and project participation, such protocols and pathways

shall not (1) override the professional judgment of Partner Organization and its licensed health care professionals in treating patients in individual cases or (2) interfere with the governing body/established operator of any licensed health care facility or its medical staff in overseeing the provision of clinical services to patients and the quality of care

Clinical Guideline Board Approval History: 08/09/2016

Clinical Guideline Revisions:

Date	Revision Log	Updated By
6/15/2016	Original Creation	Emily Balmer
08/09/2016	Board of Directors approval	D. Sculley

This Clinical Guideline shall be reviewed periodically and updated consistent with the requirements established by the Board of Directors, Care Compass Network's senior management, Federal and State law(s) and regulations, and applicable accrediting and review organizations.