• High ED and Hospital Use
• Without routine medical care
• Substance Abuse Issue
• Mental Health Issues
• Poor control of chronic disease
• Acute Illness
• Homeless / Unstable Housing
• Pressing Social Needs
• Complicated Health Needs

<table>
<thead>
<tr>
<th>Level of Care 1 Patient</th>
<th>• Complicated Health Needs</th>
<th>• Pressing Social Needs</th>
<th>• Homeless / Unstable Housing</th>
<th>• Acute Illness</th>
<th>• Poor control of chronic disease</th>
<th>• Substance Abuse Issues</th>
<th>• Mental Health Issues</th>
</tr>
</thead>
</table>

| Level of Care 2 Patient | • Attended PCP Appointment | • Stabilized Social Needs | • Improved Stability in Housing | • Stabilizing Mental Health / Substance Abuse Issues | • Continues to need frequent follow-up to care for chronic diseases | • Continues to need assistance accessing health care system |
|------------------------|---------------------------|------------------------|-----------------------------|----------------|-----------------------------|------------------------|-----------------------|

| Level of Care 3 Patient | • Health and Social Stabilization | • Consistently meets with PCP | • Received referrals for all social service needs | • Continues to need support with chronic diseases / behavioral health issues | • Reduced Hospital and ED use |
|------------------------|---------------------------|------------------------|-----------------------------|----------------|-----------------------------|------------------------|-----------------------|

<table>
<thead>
<tr>
<th>Level of Care 4 Patient</th>
<th>• Patient Training</th>
<th>• Hand off to PCP</th>
<th>• Regularly attends PCP appointments</th>
<th>• Medically and Socially Stable</th>
<th>• Ready for Patient Training</th>
<th>• CMT to re-engage if worsening of health / social well-being</th>
</tr>
</thead>
</table>

### Care Management Intervention

#### Level of Care 1 Intervention
- Weekly Home Visits
- Interim Phone Calls
  - **Clinical**:
    - Comprehensive Health Assessment
    - PCP follow up
    - Disease Management Education
    - Other provider coordination
    - Medical Goal Setting
    - Relationship Building

#### Level of Care 1 Intervention
- Weekly Home Visits
- Interim Phone Calls
  - **Social**:
    - Social History
    - Psycho/Social Assessment
    - Home Care Coordination
    - Behavioral Health
    - Entitlements / Benefits
    - Nutrition Referral
    - IDs
    - Emergency Shelter
    - Goal Setting
    - Prescription Assistance
    - Relationship Building

#### Level of Care 2 Intervention
- Bi-weekly Home Visits
- Interim Phone Calls
  - **Clinical**:
    - PCP/Specialty Coordination
    - Clinical Reinforcement
    - Chronic Disease Management
    - Medication Management
    - Patient Education & Advocacy
    - Relationship Building

#### Level of Care 2 Intervention
- Bi-weekly Home Visits
- Interim Phone Calls
  - **Social**:
    - Follow up on Applications
    - Follow up on referrals
    - Patient support and empowerment
    - Relationship Building

#### Level of Care 3 Intervention
- Monthly Visits & Hand off to Health Coaches
  - **Clinical**:
    - Determine Goals for Health Coaches
    - Follow up on outstanding medical needs

#### Level of Care 3 Intervention
- Monthly Visits & Hand off to Health Coaches
  - **Social / Coordination**:
    - Determine Goals for Health Coaches
    - Follow up on outstanding social / coordination needs

#### Level of Care 4 Intervention
- Health Coaching
  - **Health Coaching**
    - Logistics Training
    - Patient can make and keep appointments
    - Patient can Arrange Transportation
    - Patient is able to arrange for a referral to a specialist
    - Patient can arrange for nutrition / food security
  - **Disease Management**
    - Chronic Disease Management Education as directed by Nurse Provider
    - Patient can communicate well with physicians and knows how to ask questions and negotiate an agenda
  - **Social Skills**
    - Patient knows how to find available resources
    - Patient has been introduced to life management skills as necessary (budgeting, etc)
    - Patient can meet and set goals

#### Level of Care 4 Intervention
- Health Coaching
  - **Ongoing Support**
    - Health Coach Provides Ongoing Support

#### Level of Care 4 Intervention
- Health Coaching
  - **Patient Training**
    - Complete Final PCP Hand Off
    - Patient is able to arrange for a referral to a specialist
    - Patient knows how to find available resources
    - Patient can meet and set goals

---

**Legend**
- Weekly Home Visits
- Interim Phone Calls
- As directed
- Appointments
- Transportation
- Home Visits
- Interpretation
- Social Support
- Level of Care 1 / 2 Intervention
  - Coordination / Health Coaching
  - Determined Goals for Health Coaches
  - Follow up on outstanding medical needs
  - Follow up on outstanding social / coordination needs

---

**Intervention**
- Monthly Visits & Hand off to Health Coaches
  - Prepared Goals for Health Coaches
  - Follow up on outstanding medical needs

---

**Coordination**
- Monthly Visits & Hand off to Health Coaches
  - Prepared Goals for Health Coaches
  - Follow up on outstanding medical needs

---

**Hand off Meeting**
- Hand off Meeting
  - Completed
  - Begin Level 4 Interventions

---

**Hand off**
- Hand off Meeting
  - Completed
  - Begin Level 4 Interventions

---

**Health Coaching**
- Health Coaching
  - Logistics Training
  - Patient can make and keep appointments
  - Patient can Arrange Transportation
  - Patient is able to arrange for a referral to a specialist
  - Patient can arrange for nutrition / food security
  - Disease Management
  - Chronic Disease Management Education as directed by Nurse Provider
  - Patient can communicate well with physicians and knows how to ask questions and negotiate an agenda
  - Social Skills
  - Patient knows how to find available resources
  - Patient has been introduced to life management skills as necessary (budgeting, etc)
  - Patient can meet and set goals

---

**Health Coach Provides Ongoing Support**
- Health Coach Provides Ongoing Support
  - Patient is able to arrange for a referral to a specialist
  - Patient knows how to find available resources
  - Patient has been introduced to life management skills as necessary (budgeting, etc)
  - Patient can meet and set goals