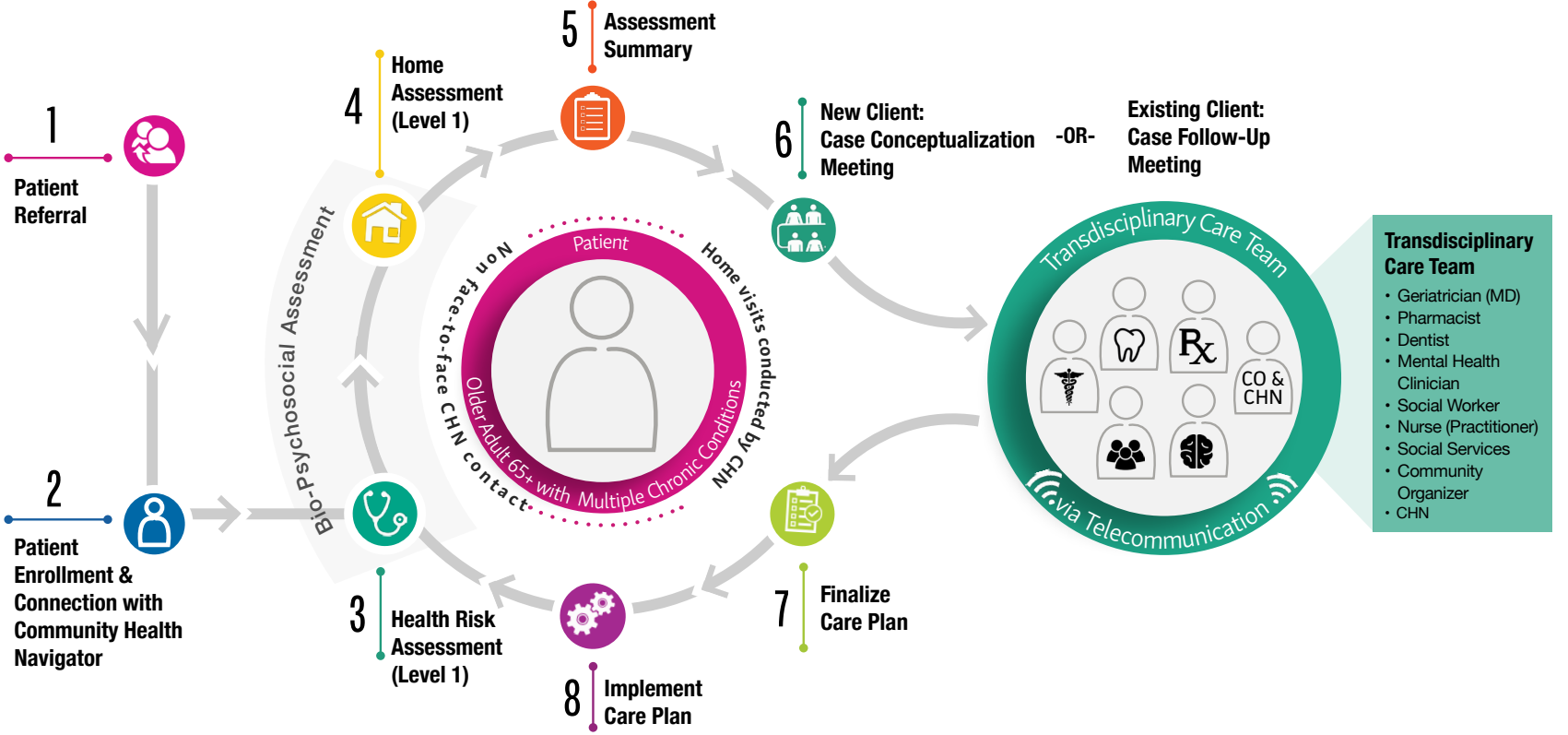
1
Patient Referral
2
Patient Enrollment & Connection with Community Health Navigator
3
Health Risk Assessment (Level 1)
4
Home Assessment (Level 1)
5
Assessment Summary
6
New Client: Case Conceptualization Meeting
-OR-
Existing Client: Case Follow-Up Meeting
7
Finalize Care Plan
8
Implement Care Plan
Bio-Psychosocial Assessment
Patient
Non face-to-face CHN contact
Home visits conducted by CHN
Older Adult 65+ with Multiple Chronic Conditions
Transdisciplinary Care Team
via Telecommunication
CO & CHN
Transdisciplinary Care Team
• Geriatrician (MD)
• Pharmacist
• Dentist
• Mental Health Clinician
• Social Worker
• Nurse (Practitioner)
• Social Services
• Community Organizer
• CHN