Camden Coalition of Healthcare Providers

Triage tool: Developing a standard for dosing and delivery of your intervention can strengthen the impact and value case. Adapt this tool to reflect the core components and standard for your intervention.

	Red: **In Crisis**	Yellow: **Vulnerable**	Green: **Stable/Empowered**	Blue: **Graduated/Monitored**
Utilization Characteristics	Met program criteria: 10 ED in 2 yrs and/or 4 IP in 2 yrs OR 5 ED in 1 yr and/or 2 IP in 2 yrs	Continuing IP admits or ER visits	Not regularly admitting to IP or visiting ER	Not regularly admitting to IP or visiting ER
Program Characteristics	Rapid cycle comprehensive intervention focused on stabilizing patient	Plan in place to address gaps in medical and social needs Vacillates between crisis/disengaged and stable/engaged	Connections have been made with services; patient is stable Patient may be awaiting income source to help obtain insurance or pay for medications	All identified domains have been addressed
Average Score Per Domain (SDOH or other tool)				
Medical Characteristics	Hospice appropriate Acute sx uncontrolled Acute dz uncontrolled No access to PCP No access to regular specialty care	Plan in place for hospice Plan in place to address acute sx Plan in place to address dz Plan in place to connect with PCP No access to regular specialty care	Connected to hospice All acute symptoms managed to be chronic Disease managed, with assistance from complex case manager Connected with PCP Connected with regular specialty care	Transitioned into hospice care Connected to specialty provider and EB symptom management plan Connected to site case manager or BH provider for persistent mental illness Connected to PCMH/case manager to manage disease, (or can independently manage disease) Connected to PCP Connected to regular specialty care
Social Characteristics	Homeless/unsafe housing Suicidal and/or danger to others Active substance abuse with required Tx Food access/insecurity issues	Plan in place for housing and/or safe housing environment Plan in place to address mental health Plan in place to address substance abuse Plan in place to address food access	Plan in place for housing or housed Connected to mental health services Substance abuse addressed Food insecurity addressed	Housing is stable and safe Connected to mental health services Substance abuse addressed and in treatment Has reliable food supply
Type/Frequency of Engagement	2-3x/week in-person or phone 15-20 hours intervention follow-up work (2 hours for initial visit)	2x/month in-person or phone 10 hours intervention follow-up work	1-2 month in-person or phone 0-2 hours intervention follow-up work	Monitor 1x month by CHW or MA via phone Round on all inpatient visits (closed, active, disenrolled)
Core Components	Focus on connecting with PCP, mental health providers/treatment, transportation, housing, medication, SNAP Screen for insurance/disability/SS benefits	Focus on building sustainable provider relationships	Focus on building source of income (disability or job)	Focus on maintaining adequate income Focus on retaining relationships and connection to socialization for stabilization
Increase Engagement when:		Reassessment of xxx scores decrease utilization	Patient has pattern of 5+ ED visits	5+ ED visits and/or 2+ IP admissions in 6 months Social needs move into "Red" category

This resource was shared as part of the Building the Value Case for Complex Care Toolkit from the National Center for Complex Health and Social Needs, an initiative of the Camden Coalition. Find the full toolkit at www.nationalcomplex.care/value-case.