Connecting Those at Risk to Care

The Quick Start Guide to Developing Community Care Coordination Pathways

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A Companion to the Pathways Community HUB Manual

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The information in the *Connecting Those at Risk to Care* quick start guide is intended to assist community care coordination initiatives in identifying at-risk individuals, clarifying their risk factors, and then ensuring risk factors are addressed using pathways and a pay-for-performance methodology. This guide is intended as a reference and not as a substitute for professional judgment. The findings and conclusions are those of the authors, who are responsible for its content, and do not necessarily represent the views of AHRQ. No statement in this guide should be construed as an official position of AHRQ or the U.S. Department of Health and Human Services. In addition, AHRQ or U.S. Department of Health and Human Services endorsement of any derivative products may not be stated or implied. None of the investigators has any affiliations or financial involvement that conflicts with the material presented in this guide.

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Overview

This Quick Start guide complements *Pathways Community HUB Manual: A Guide To Identify and Address Risk Factors, Reduce Costs, and Improve Outcomes*, initially published in 2010 by the Agency for Healthcare Research and Quality (AHRQ). The publication provides a detailed overview of the Pathways Community HUB (HUB) Model. The HUB is a community care coordination approach focused on reducing modifiable risk factors for high-risk individuals and populations.

The HUB relies on community care coordinators (CCCs)—community health workers, nurses, social workers, and others—who reach out to at-risk individuals through home visits and community-based work. Once an at-risk individual is engaged, the CCC completes a comprehensive assessment of health, social, behavioral health, economic, and other issues that place the individual at increased risk. Each identified risk factor is tracked as a standardized Pathway that confirms the risk is addressed through connection to evidence-based and best practice interventions.

The Pathway is a tool for confirming that the intervention has been received and that the risk factor has been successfully addressed. The Pathway also serves as the quality assurance and payment tool, and it is used by the CCC to ensure that each risk factor is addressed and that outcomes have improved.

When this model is deployed across multiple agencies within a community, the centralized HUB helps agencies and CCCs avoid duplication of effort. The HUB serves as a communitywide networking strategy that helps isolated ("siloed") programs become a quality-focused team to identify those at risk and connect them to care.

The HUB model was first developed by the Community Health Access Project (CHAP) in Mansfield, Ohio, with leadership from Drs. Sarah and Mark Redding. The model involves working across organizational silos within a community (CHAP worked with multiple stakeholders in three counties) to reach at-risk individuals and connect them to health and social services that yield positive health outcomes. The model is now part of a national network of community-based initiatives (Appendix A) working under a common set of national standards and certification developed by the Pathways Community HUB Institute.

This quick start guide is a reference and resource for public and private stakeholders engaged in improving the community care coordination system for identifying high-risk individuals; documenting their specific health, social, and behavioral health risk factors; and addressing those risks in a pay-for-performance approach. The HUB focuses on individuals and populations, and it provides coordination, measurement, and impact data that can help guide local and regional policies and reimbursement strategies. The target audience includes all those involved in the design, implementation, and financing of care coordination services, especially within the community setting.

This guide includes an overview of the process, as well as tools and resources needed to develop a HUB. Additional information on the HUB model and Pathways is available in the full manual.

Why Create a Pathways Community HUB?

A Pathways Community HUB is an effective strategy for achieving the goals of improved health, social, and behavioral health outcomes and reduced health care costs.

Reason #1: To Catalyze the Goals of Health Care Reform

The Patient Protection and Affordable Care Act is intended to improve population health and quality of care while containing costs. One of the key strategies for meeting these goals is the development of accountable care organizations (ACOs). ACOs need to provide the populations they serve with appropriate, timely access to high-quality, well-coordinated health and social services that improve health and contain health care costs. The HUB serves as a framework that can help communities and ACOs improve population health and lower costs.

Through communication, collaboration, and built-in incentives, the HUB increases the efficiency and effectiveness of care coordination services, especially in the community setting. Specific checklists and Pathways have been developed to ensure that at-risk individuals are identified, that their risk factors are assessed, and that each risk factor is tracked using a specific standard Pathway. Rather than allow providers of health and social services to continue functioning in isolated silos, the HUB requires them to work collaboratively, reaching out to those at greatest risk and connecting them to evidence-based interventions, with a focus on prevention and early treatment.

To ensure quality and accountability across all providers of care coordination services, the HUB acts as a central clearinghouse that "registers" and tracks at-risk individuals, making sure that their health, behavioral health, social, environmental, and educational needs are met. The HUB provides ongoing quality assurance that results in less waste and duplication of care coordination services, lower costs, improved health status, and fewer health disparities.

The HUB provides both an individual- and a population-focused approach to identify at-risk populations, assess their risk factors, and ensure that each modifiable risk factor is addressed with evidence-based or best practice interventions using Pathways. Payments in this model are closely tied to the production of positive outcomes (completed Pathways).

Reason #2: To Pay for Value, Not Volume

Communities that are ready to work toward an accountable system focused on identifying and reducing risk factors using the HUB model can face significant challenges. Connecting those at risk to timely, high-quality care requires expertise, accountability, and investment. Our current business model for providing care coordination services reimburses based on caseloads and chart notes. Care coordination contracts typically purchase "work products" and processes but are not tied to meaningful outcomes for the individual.

In January 2015, the U.S. Department of Health and Human Services (HHS) announced the next phase in improving health care.[1] The next phase includes three components:

- Using incentives to motivate higher value care by increasingly tying payment to value through alternative payment models;
- Changing the way care is delivered through greater teamwork and integration, more effective coordination of providers across settings, and greater attention by providers to population health; and
- Harnessing the power of information to improve care for patients.

The net cost of operating HHS in fiscal year 2012 was $855.5 billion, with most of those costs (more than 94 percent) related to Medicare and other health programs.[2] A primary focus of the Government's health care spending is to produce positive health outcomes; unfortunately, that is not the case. A 2013 brief by the Institute of Medicine[3] summarized that "Not only are their lives shorter, but Americans also have a longstanding pattern of poorer health that is strikingly consistent and pervasive over the life course—at birth, during childhood and adolescence, for young and middle-aged adults, and for older adults."

A focus on assessing and addressing risk factors at the individual and population levels represents a substantial opportunity for improving health outcomes. Very little of the current funding is strategically focused on identifying and addressing the critical risk factors that produce adverse health outcomes.

Reason #3: To Embrace a Comprehensive Approach Focused on Risk Factor Reduction

Working to improve health outcomes requires more than access to medical care; it encompasses behavioral health, as well as social, environmental, and educational factors—the "social determinants of health." All of these factors must be addressed in a holistic and comprehensive manner in order to improve health for an individual or a population. Some risk factors are addressed at the individual level: housing, smoking cessation, insurance, medical home, employment, adult education, and evidence-based parenting instruction. For each of these issues there are specific evidence-based and best practice interventions available that can address the risk factor.

There are also risk factors that need to be addressed at the population level, such as neighborhood safety, access to nutritious food, and environmental pollution. Population-level risk factors are recognized as also being critical interventions to improve outcomes. The HUB model primarily focuses on individually modifiable risk factors but can provide important data about the population's health as well. As most identified risk factors responsible for adverse health outcomes are related to social determinants of health, a comprehensive approach is critical.[4]

Current care coordination contracts are primarily focused on "work products" (e.g., caseloads, phone calls, forms completed) and not on connecting at-risk clients to services they need. In addition, there is no incentive for the multiple agencies providing care coordination services to communicate or collaborate with each other, leading to duplication and inefficiencies.

The HUB model provides the infrastructure to manage multiple sources of care coordination funding across the community network. The concept of "braided funding" is possible because of Pathways. One individual may receive care coordination through several health and social service agencies, but in the current system the duplication of service is not easy to identify. The HUB allows collaboration among funders to more fully support and address all the needs of an at-risk community member. Unnecessary duplication is identified and eliminated.

The Pathways methodology allows one care coordinator to work with a client to address multiple Pathways. The funding that supports each of these intervention areas can be organized by assigning specific funders to specific Pathways. For example, a health plan may pay for medically focused Pathways, while other agencies may pay for social service Pathways. There are examples of a broad array of care coordination funding streams within the current HUBs, including Medicaid, managed care plans, United Way, housing providers, health departments, behavioral health, property taxes, and others.

How To Create and Use a Pathways Community HUB

The HUB Model

A Pathways Community HUB represents a network of care coordination agencies focused on reaching those at greatest risk and addressing their identified risk factors. The care coordination agencies may represent any agency deploying community care coordinators (CCCs)—community health workers, nurses, social workers, or others—to reach out to individuals and to help them connect to care. Agencies include local community organizations, outreach centers, health departments, and care coordinators who are part of a community health center.

The central HUB agency is responsible for leading the network and developing the contracts and requirements for participating care coordination agencies. The HUB is responsible for ensuring that the national standards for Pathways Community HUBs are built into the accountability, function, and billing process for the network.

The HUB, by definition, is a neutral entity that does not directly provide care coordination services. The HUB gathers the multiple care coordination agencies together into an organized team, trains and supports them to identify those in the community at greatest risk, and assesses and tracks each modifiable risk with standardized Pathways. National HUB certification through the Pathways Community HUB Institute (HUB Institute) is becoming a greater focus and requirement of funders and policymakers.

The HUB usually employs two or three administrative staff and does not represent a large additional layer to the existing system. The cost savings that result from eliminating duplication, producing positive outcomes, and realizing related efficiencies far exceed any additional cost for this central organizational component of effective community care coordination. As noted, the HUB does not hire or deploy care coordinators but rather supports, coordinates, and tracks outcomes for all the agencies that do provide the direct on-the-ground, community-based care coordination.

Regional organization and tracking of care coordination

Community HUB

Care coordination agencies

HUB—Client Coordination
- Demographic Intake
- Initial Checklist ⟶ assign Pathways
- Regular home visits—checklists and Pathways completed
- Discharge when Pathways complete (no issues)
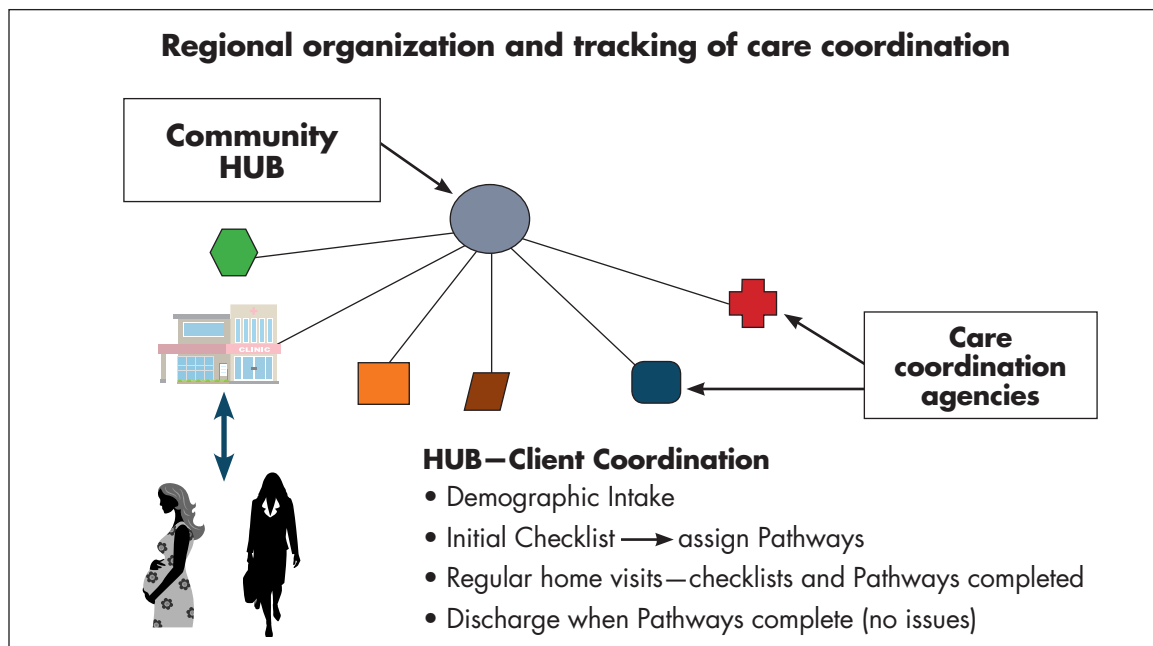
The Pathways Community HUB model is best summarized in three steps:

     1. Find

     2. Treat

     3. Measure

1. Find

The HUB model represents a network of agencies that deploy CCCs, in a home-visiting methodology, to engage at-risk individuals in Pathways-focused care coordination. The central HUB of the network does not employ the care coordinators but serves as a central point of organization, quality measurement, tracking, and billing for the agencies that do. The HUB as a network is designed to specifically focus on at-risk individuals as defined by the community.

Communities considering this model need to complete, or have access to, a thorough, up-to-date community needs assessment to determine the population of interest. Examples of recommended strategies for the assessment process include geocoding of health and social data, risk-scoring methodology, screening tools, and key stakeholder surveys that encompass at-risk community members. When the HUB is operational, strategies must be developed not only to "find" the at-risk individuals, but also to engage them in care coordination services.

When a new client is discovered through referral or community outreach, all of the required paperwork to protect personal health information must be completed by the CCC and submitted before the client can be registered as a new client in the HUB. A key role of the HUB is to monitor and notify CCCs of any duplication of service. Once engaged, the CCC and individual are linked in the HUB, and the HUB will flag any further attempts to register that person for care coordination services. It may be appropriate for an at-risk individual to have more than one care coordinator, but the reasons behind that decision need to be clear.

The data collection process begins once an individual is engaged by a CCC. Initially, data are captured in a standardized demographic intake form and initial checklist. The checklist must represent a comprehensive assessment of health, behavioral health, and social service risk factors. There is flexibility in the way that different communities develop their checklists, but the information gathered should identify any of the risk factors that may lead to poor health outcomes.

2. Treat

For each risk factor identified, a specific standardized Pathway is assigned, and then each Pathway is tracked step by step through completion. An at-risk individual may have many Pathways being addressed simultaneously, reflecting multiple health and social issues identified by the CCC. The completion of each Pathway ensures the delivery of one or more evidence-based or best practice interventions to address the risk factor.

3. Measure

Pathways are the standardized outcome measurement tools the HUB tracks. As risk factors are identified and addressed, the Pathways are completed and a reduction in risk is recorded. HUBs need to have the capacity to measure and track an individual's risk status over time. Some HUBs are looking at risk reduction in specific areas, such as health, behavioral health, social factors, and financial security, and

are using these data to study the impact of care coordination over time. A key element of health system transformation is this intense focus on what factors are actually causing the poor health outcomes in a community and how these factors can be addressed most quickly and cost effectively.

The effectiveness of Pathways used as a single measure and as a comprehensive group of measures has been tested and researched. The model and its impact affirm that like many other effective interventions that require more than one component, more than one risk factor must be addressed to demonstrate changes in health outcomes. The comprehensive nature of the assessment and the use of multiple Pathways are critical to achieving positive outcomes.[5] The measurement of specific items within the Pathways and multiple specific Pathways was conducted by Westat as part of a National Institutes of Health initiative. Testing of single Pathways and groups of Pathways in further studies could be very beneficial to the development of this model.

To receive HUB certification by the national HUB Institute, a HUB must use the standardized Pathways. A complete list of the 20 approved Pathways, as well as a chart used with two of the Pathways, can be found in Appendix B. Pathways are specifically designed to be clear and concise. Although a new HUB is not required to use all 20 Pathways as it starts up, it is expected to gain experience with the Pathways and then develop new Pathways when needed, with the support of the HUB Institute. By standardizing the Pathways, HUBs can compare outcomes across care coordinators, agencies, communities, regions, and States. Standardization also allows the development of universal billing codes to tie payment to outcomes. In Ohio, Medicaid managed care plans have developed contracts based on Pathway completion.

Many communities want to track more comprehensive measures, such as overall reductions in emergency department visits, improvements in hemoglobin A1c, and reductions in hospital readmissions. The HUB continues to track individual Pathways but can also "bundle" Pathways together to achieve a larger objective. For example, to reduce emergency department visits, most individuals may need to receive:

- Ongoing primary care (Medical Home or Medical Referral Pathway);
- Help with medication (Medication Assessment or Medication Management Pathway);
- Education about their conditions, medication, or needed services (Education Pathway);
- Help with housing (Housing Pathway); and
- Help with barriers to connecting to other social services (Social Service Referral Pathway).

The Pathway bundle has a specific billing code, and funders can offer an incentive payment if all of the identified Pathways are successfully completed.

For a given individual, some Pathways may not be completed and the desired outcomes may not be reached. The Pathway still needs to be closed, but it is recorded by the HUB as "finished incomplete." Pathway incompletion is actually very important data for the HUB to monitor. The CCC is required to document why the Pathway was not successfully completed. The HUB can track which Pathways are not completed and compile the reasons. For example, Pathways may not be completed because the resources are not available in a community. The community can use these data to evaluate gaps in services or other issues that can be addressed on a policy level.

Pathways are the metric that focuses on successful resolution of an identified issue. Pathways are also the mechanism the HUB uses to tie financial accountability to completion. Recent peer-reviewed publications have demonstrated a significant improvement in outcomes and cost savings using this model.[5] We know that delivering health and social services from silos does not work. The HUB provides the infrastructure communities need to support multiple and diverse agencies and related resources so they can work collaboratively to address health inequities and achieve real improvements for at-risk individuals.

Key Insights and Lessons Learned in Developing an Effective Community HUB

Pathways Community HUBs start in a variety of ways. Most HUBs have developed through the efforts of a small group of community-focused individuals determined to make a difference for their most at-risk citizens. For example, in Albuquerque, New Mexico, the HUB started with two community organizers from the university and a county commissioner. The HUB in Toledo, Ohio, was built with the help of a local pediatrician and the director of a hospital network. The original HUB in Mansfield, Ohio, was built through collaboration with local physicians and community leaders. HUBs are transformative by design, and it takes a determined core group of individuals with vision and dedication to make a HUB a reality.

The HUB's primary focus must be on finding those most at risk in the community and ensuring that risk is reduced, leading to better health outcomes and lower costs. It is essential that the right community partners be engaged in this process to allow appropriate connections to be established in building the network. A sense of community support and ownership is critical in lending ongoing support to the HUB. Most communities begin with a segment of the at-risk population, such as high-risk pregnant women, adults with multiple chronic conditions, or frequent users of hospital emergency departments. Once the infrastructure is in place, HUBs are designed to grow as the community gains experience with the model.

Pathway funders need to be engaged at the very beginning of the community discussion about implementing a HUB. Health plans, hospitals, social service agencies, ACOs, foundations, and other identified "Pathway purchasers" need to be involved in defining the at-risk population and standard Pathways to be used. It is a major transition for care coordination agencies to move from working in competitive silos to working as an unduplicated team with contracts and payments focused on outcomes. It is important to have adequate support and incentives in place to move communities toward this accountable, business-focused model.

Strong care coordination agencies that are effectively serving high-risk community members will usually find that their reimbursement is increased with the HUB approach. Agencies that are not successfully engaging at-risk individuals or that do not follow up to connect them to services will not do well with this model. Payment is based on outcomes, and agencies must be able to confirm that risk factors have been effectively addressed.

To achieve sustainability, the HUB must develop and work toward expanding the number of funders supporting the HUB network. Agreements with the funders are designed to reflect the risk identification and risk reduction components of the HUB model. The HUB Institute has developed coding strategies for Pathways that can be used with multiple funders to achieve "braided funding." Individuals at high

risk for poor health outcomes have many different risk factors, and one funder usually cannot cover all the Pathways that need to be addressed. Identifying which funders will pay for specific Pathways is essential to developing braided funding and to adequately funding the CCC.

As CCCs in the field start to reach out and engage those at greatest risk, they begin the data collection process by completing the comprehensive assessment. As they use Pathways to address the risk factors identified by the assessment, they must have an effective data flow and evaluation methodology in place. Simple operational reports for CCCs, supervisors, and administrators are essential. These reports allow a quick view of how this "outcome production" process is moving along at all levels: individual, CCC's caseload, agency, and across the entire HUB network. The reports are critical for the model to reach its maximum potential.

The questions that reports should answer include: "Are we reaching those at greatest risk?" "What risk factors are being identified within the population we are serving?" "How much time does it take to address these risk factors?" "Which care coordinators and which agencies are able to address the risk factors the fastest?" "What strategies are the most efficient care coordinators and agencies using to quickly address the risk factors?" "What risk factors are taking the longest to address or cannot be addressed, and what are the reasons?"

Getting effective technical support and carefully understanding the evidence-based standards and principles of the HUB model is essential to developing effective HUBs. The HUB Institute was created to provide technical assistance in key areas of model implementation, especially in support of the national standards. The original Community Care Coordination Learning Network (CCCLN), supported by AHRQ, provided the foundation for the development of the national certification process. There are also vendors available to provide operational support to HUBs with regard to implementation, training, technology, and contracting for care coordination services.

Newly developed and existing HUBs need to focus on and work toward national HUB certification. When the CCCLN evaluated HUBs that developed over the past 10 years, it found that as many as one-third were not successful or sustainable. HUBs that did not seek specific technical support for the model and did not focus on the evidence-based standards were unable to demonstrate outcomes. It is very difficult to make a case to funders to support the HUB infrastructure without demonstrating improved outcomes and reduced costs. HUBs that focus on the national standards and enroll in certification demonstrate significantly better outcomes and sustainability.

Overview of the Pathways Community HUB Prerequisites and Standards

HUB directors, public health leaders, third party payers, policymakers, and other community stakeholders have requested certification of the HUB model. This certification provides standards and expectations for HUB implementers and payers. The HUB Institute—with funding from the Kresge Foundation and in partnership with the Community Health Access Project, Communities Joined in Action, Georgia Health Policy Center, and Rockville Institute—is leading the HUB certification process.

Certification supports current and future HUBs by requiring (1) the evidence-based and best practice components known to be essential for high-quality community care coordination services and (2) an efficient regional infrastructure that can lead to improved health outcomes and reduced costs. The

standards support a basic framework of quality that encourages local variation and innovation within various cultural and geographic settings. Certification enables funders and policymakers to make wise investments in care coordination services that ensure quality, health improvement, and the value of contracted services.

The complete prerequisites and standards for HUB certification can be found at the HUB Institute Web page.[6] This section highlights some of the key elements that are required.

Governance Documents

By definition, the HUB is a neutral and independent legal entity that has legal capacity to enter into agreements or contracts (Prerequisite #1). Many of the certification prerequisites and standards tie directly into the governance of the HUB, including the following items.

Prerequisite #6

- The HUB coordinates a network of care coordination agencies serving at-risk clients. The HUB must have legal documents describing the relationship between the HUB and care coordination agency members.

- The HUB model is designed to use what is already working in communities, including existing care coordinators and agencies. Most communities have funding in place for a variety of care coordination work, but the infrastructure for creating a network of agencies together is lacking.

Prerequisites #8 and #9

- The HUB must have contracts with a minimum of two payers to ensure comprehensive and sustainable care coordination services. Contracts must confirm that a minimum of 50 percent of all payments are related to an individual's intermediate and final outcomes/Pathway steps.

Prerequisite #10

- The HUB must document that it complies with the Health Information Privacy and Accountability Act through training, policies, and signed agreements.

Prerequisite #11

- The HUB needs to operate in a transparent and accountable manner and needs to have policies around conflict of interest and distribution of referrals to care coordination agency members. It is a requirement that the HUB not directly provide care coordination services.

Needs Assessment

Prerequisite #5

- The HUB reviews and/or conducts community needs assessments. This assessment should include local data specific to medical, behavioral health, social, environmental, and educational factors and guide the HUB in its efforts to improve health and reduce inequities. The HUB needs to show how it uses the community needs assessment to identify the populations to be targeted for community care coordination services.

Care Coordination Program Requirements

The HUB creates agreements with each care coordination agency to delineate expectations around hiring, training, and supervision of CCCs. In addition, the administrative staff of the community agencies need training and support to become part of a network of agencies focused on finding those most at risk and connecting them to care. Experienced, capable, and creative HUB leadership is needed to help agencies move away from being competitive silos and make the transition toward functioning as a team.

Standards #5 and #19

- The HUB is responsible for monitoring the performance of its care coordination agency members and for improving the quality of care coordination services. Written agreements are required to ensure clarity and transparency of the roles of the HUB and care coordination agency members and the financial arrangements between them.

Standard #6

- Many of the HUB standards define policies and expectations for participating programs, agencies, and providers or for community care coordination services. Standard #6 requires the HUB to have operational policies and procedures in place that cover client enrollment, allocation and monitoring of referrals, documentation requirements, ratios of CCCs to clients, and other key operational items.

Data Collection and Payment System Linked to Outcomes

Pathways

Prerequisite #7

- The HUB is required to use standardized Pathways. Appendix B defines all 20 Pathways approved by the HUB Institute. Pathways must be used as defined, and new Pathways cannot be developed without submission to the HUB Institute for review. Pathways outline key stages required for the delivery of high-quality and efficient care coordination services. Each Pathway focuses on one significant client need or problem and identifies and documents the key steps that lead to a desired, measurable outcome. In addition, standardized Pathways allow research, evaluation, and best practices using standard metrics.

Prerequisite #9

- The 20 standardized Pathways link billing codes to Pathway steps. Payment for outcomes is a key component of the HUB model and promotes accountability, quality, equity, health improvement, and value. Contracts with payers must specify that at least 50 percent of all payments are related to an individual's intermediate and final Pathway steps.

- Prior to the launch of HUB operations, a tracking and payment system must be developed that rewards participating organizations and individuals based on the completion of Pathways. Participating agencies within a HUB must be rewarded and incentivized to work in collaboration with other agencies to reach those at greatest risk and connect them to care, recognizing that those individuals require more time and expertise to serve.

- Community agency directors and staff must also receive basic training related to the HUB model. The invoices they submit are also reports of the outcomes achieved during the billing period. Understanding the connection between higher quality of service and the payment structure is critical to those administering and leading the care coordination agencies.

Client Information

Standard #13

- The HUB must collect client demographics and other relevant information to effectively address the medical, behavioral health, social, environmental, and educational needs of the at-risk client. Appendix C is an example of a demographic intake form, which is used to obtain key information about the client upon enrollment in the HUB. Checklists capture specific information about the client's health and social issues at each face-to-face encounter. The checklists should document any identified risk factors and provide information for the initiation of Pathways.

  A more comprehensive checklist is used at the initial visit, and shorter checklists are used on an ongoing basis to monitor changes between visits. Appendix D is an example of a checklist used for adult clients. Other client information can be gathered through standard tools or screens, such as the Patient Health Questionnaire 9 (PHQ9), a depression screener; Ages & Stages Questionnaire (ASQ); and Patient Activation Measure (PAM).

Risk Assessment

Standard #14

- To ensure an at-risk individual's needs are being addressed and met—and an efficient use of limited resources—the HUB assesses and monitors each client's risk factors. The HUB must be able to describe how risk measurement translates into intensity of care coordination services.

Data System

Standards #17 and #18

- The HUB tracks, monitors, and reports on client services and promotes collaboration, intersectoral teamwork, and community–clinical linkages. Although a complex data system is not mandatory, the HUB needs to develop accurate and efficient methods for tracking and monitoring data collection for at-risk clients. Most HUBs will rely on information technology to perform this task. Whatever approach is used, this system must ensure the protection of client information at all times.

- The HUB ensures that clients (1) are identified and engaged; (2) are evaluated to determine their needs, risk factors, and risk level; (3) have an individualized care plan; (4) are assigned to appropriate standardized Pathways; (5) are monitored through the completion of the appropriate Pathways; (6) receive home visits; (7) are reevaluated to determine needs, risk level, and service adjustments; and (8) are discharged when their needs are met. Communication and data sharing among practitioners, agencies, CCCs, and the client help ensure quality and continuity of services.

Quality Assurance

Standard #8

- The HUB is responsible for monitoring and improving the quality of care coordination services provided to those who are at risk. Therefore, the HUB must have a quality improvement plan and must regularly evaluate its services as well as those services provided by care coordination agency members. The HUB quality improvement plan should describe how quality improvement projects are selected, managed, and monitored. The HUB needs a communication strategy that covers planned quality improvement activities and processes and how updates will be communicated regularly to all involved.

Standard #19

- This standard emphasizes that the HUB must monitor the performance of its care coordination agency members and offer technical assistance to ensure quality and client safety.

Community Care Coordinator Requirements and Training

Many different types of professionals can serve as community care coordinators, including social workers, community health workers, nurses, and case managers. By definition, these individuals spend the majority of their time meeting face-to-face with clients in a community setting, including the home. To ensure the provision of high-quality services and effective collaboration across all providers, each HUB should develop basic human resource requirements for care coordinators, along with a comprehensive training program. Individuals receiving care coordination services are often dealing with complex health and social issues, and community care coordinators need adequate preparation. The HUB should have clear policies and procedures on all aspects of training, documentation, and accountability for results.

Standard #9

- The HUB model of care coordination focuses on improving health, advancing equity, improving quality, and eliminating disparities, and all HUB and care coordination agency personnel must complete cultural competency training.

Standard #10

- Community care coordinators are supported and supervised by a competent professional, working within the scope of his or her license. The level of supervision varies based on the training of the community care coordinator. It is required that community health workers have supervisors who review and sign off on documentation.

Standard #12

- Education, training, and support for community health workers and for community care coordinators other than community health workers are essential to achieve improved outcomes for those clients at risk. The HUB must provide documentation that community care coordinators meet the minimum training requirements required as part of certification.[6]

Closing Summary

The identification and strategic reduction of an individual's risk factors represent an opportunity to address disparities and reduce costs. The Pathways Community HUB model builds the community infrastructure and provides the tools, standards, and strategies to implement this approach for individuals and populations. Across the Nation, there are effective and capable community organizers; with support, they can use existing resources to implement this HUB model and bring about transformative change.

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Appendix A. Pathways Community HUBs From Network Involved in National Certification

Learning Network HUBs With Provisional Certification

Name of Agency and Initiative	Address	Web Page	Names - Leadership	Contact Information
Hospital Council of Northwest Ohio Northwest Ohio Pathways HUB	3231 Central Park West Drive, Suite #200 Toledo, OH 43617	www.hcno.org	Jan L. Ruma, M.Ed., CFRE, Vice President and HUB Director Carly Miller, M.P.H., HUB Manager	(419) 842-0800 jruma@hcno.org
Pathways to a Healthy Bernalillo County	Bernalillo County New Mexico Office of Community Affairs University of New Mexico, Health Sciences Center Albuquerque, NM 87131	http://hsc.unm.edu/community/pathways/	Daryl Smith, M.P.H	(505) 272-0823 dtsmith@salud.unm.edu
Saginaw Pathways to Better Health	Saginaw County Community Mental Health Authority 500 Hancock Saginaw, MI 48602	http://saginawhub.org/	Sandra Lindsey, CEO, SCCMHA/Director, Saginaw County Community Mental Health Authority Barb Glassheim, Saginaw Pathways to Better Health Project Manager Vurlia Wheeler, Saginaw Community Care HUB Manager Linda Tilot, Director, Care Management & Quality Services, SCCMHA/ Centralized Access Home Visiting Hub	barbglassheim@comcast.net

Learning Network HUBs Working Toward Provisional Certification

Name of Agency and Initiative	Address	Web Page	Names - Leadership	Contact Information
Health Care Access Now	7162 Reading Road Suite 1120 Cincinnati, OH 45237	http://healthcare accessnow.org	Judith Warren, M.P.H., Executive Director Laverne Wiley	(513) 707-5697 jwarren@healthcareaccessnow.org
Muskegon Community Health Project	Muskegon Community Health Project/Mercy Health Partners 565 W. Western Avenue Muskegon, MI 49440	http://www.mchp.org	Peter J. Sartorius, M.A., M.S., Health Project Planning and Grants Manager Judy Kell, M.P.A., HUB Director, West Michigan Therapy	(231) 672-3201 sartorip@mchp.org
Rio Arriba Health and Human Services	1122 Industrial Park Road Española, NM 87532	www.rachc.org	Lauren Reichelt, M.A., HUB Director	(505) 753-3143 imreichelt@rio-arriba.org
Central Ohio Pathways Community HUB COPCH (developed from the local CHAP program)	35 North Park Street, Suite 132 Mansfield, OH 44902	www.CHAP-Ohio.net	Dan Wertenberger Michelle Moritz, B.S.N., RN Sarah and Mark Redding	(419) 525-2555 sredding@att.net
Care Hub, a division of Ingham Health Plan-Serving Pathways to Better Health and Early Childhood	5656 S. Cedar Street, Suite 130 Lansing MI 48911	www.ihpmi.org/carehub	Lori Noyer, Project Coordinator Robin Reynolds, Executive Director	(517) 272-4179 (Noyer) 517 272-4175 (Reynolds) lnoyer@ihpmi.org
Northeast Oregon Network (NEON)-NEON Pathways Community Hub	1802 Fourth Street, Suite A La Grande, OR 97850	www.neonoregon.org	Lisa Ladendorff, Executive Director Eric Griffith, Hub Coordinator	(541) 624-5101 (Ladendorff) lladendorff@neonoregon.org (541) 624-5101 (Griffith) egriffith@neonoregon.org

Appendix B. Community Hub Pathways

- Adult Education Pathway
- Behavioral Health Pathway
- Developmental Referral Pathway
- Developmental Screening Pathway
- Education Pathway
- Employment Pathway
- Family Planning Pathway
- Health Insurance Pathway
- Housing Pathway
- Immunization Referral Pathway
- Immunization Screening Pathway
- Lead Pathway
- Medical Home Pathway
- Medical Referral Pathway
- Medication Assessment Chart
- Medication Assessment Pathway
- Medication Management Pathway
- Postpartum Pathway
- Pregnancy Pathway
- Smoking Cessation Pathway
- Social Service Referral Pathway

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Adult Education Pathway

Initiation Client identifies educational need(s).

⬇

Partner with client to establish/review educational goals. Document goal and desired outcomes.

⬇

Assist client in registering for training or educational course: • Gather necessary documentation for registration. • Determine if client needs to take an assessment/placement exam and schedule exam date.

⬇

Confirm that client is registered in class or training program and attends first class.

⬇

Monitor client's progress with educational program. • Confirm at least biweekly that client is attending classes and document progress.

⬇

Completion Confirm that client successfully completes stated educational goal: • Course/class completed • Training program completed • Quarter/semester completed

_____
Start date

_____
_____
_____
Educational goals

_____
Date of first class

_____
_____
_____
_____
_____
_____
_____
_____
Check-in dates

Record reason if Finished Incomplete: _____
_____
_____

18

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Behavioral Health Pathway

Initiation Client with behavioral health issue(s).	Initiation date
↓	
1. Identify referral source. 2. Document behavioral health issue(s) (Describe below)	Referral Source ☐ Parent ☐ School ☐ Doctor ☐ Self-referral ☐ Other_____ _____
↓	
Schedule appointment for appropriate level of service based on client's need.	Appointment date _____ _____ Agency/provider
↓	
Completion Client has kept **three scheduled appointments**. Monitor followup appointments with Medical Referral Pathway.	_____ Kept appointment date _____ Kept appointment date _____ Kept appointment date

Describe behavioral health issue(s): _____

_____

_____

_____

Care coordination plans: _____

_____

_____

_____

Record reason if Finished Incomplete: _____

_____

_____

_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency**_____

Developmental Referral Pathway

Initiation Child <3 years with suspected developmental delays—record reason for developmental referral.	_____ Start date _____ _____ _____
Explain Part C services and review family's rights. Explain agency options to obtain developmental evaluation. Refer child to Central Intake.	_____ Reason for referral Referred to Central Intake ☐ Yes ☐ No _____ _____
1. Obtain parent/guardian consent for evaluation. 2. Assist family with scheduling developmental evaluation and obtaining a prescription from primary care provider.	_____ Reason given if "no" _____ Scheduled date of evaluation
Provide education to caregivers regarding importance of keeping appointment.	Education provided ☐ Yes ☐ No
Completion Document the date and results of completed developmental evaluation.	_____ Date of completed evaluation

Results and recommendations: _____
_____
_____
_____

Record reason if Finished Incomplete: _____
_____
_____
_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Developmental Screening Pathway

<table>
<tr>
<td>

Initiation

Child <3 years of age at risk for a developmental delay.

Child should be screened at least every 6 months using the age-appropriate ASQ or ASQ-SE.*

</td>
<td>

_____
Start date

</td>
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</table>

↓

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<td>

Educate family about the importance of developmental milestones.

Obtain consent from parent/guardian to do developmental screening.

</td>
<td>

Education provided
☐ Yes   ☐ No

</td>
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↓

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<td>

Completion

Child successfully screened using the age-appropriate ASQ or ASQ-SE.

</td>
<td>

_____
Date of screen

Circle ASQ Screen Used

2   4   6   8   9   10   12   14   16
18   20   22   24   27   30   33   36

Communication _____
Gross Motor _____
Fine Motor _____
Problem Solving _____
Personal-Social _____

Circle ASQ-SE Screen Used

6   12   18   24   30   36

Total Score _____

_____
Month/year for next screen

</td>
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<td>

No developmental concerns identified.
Discuss findings with caregivers. Record date for next developmental screen.

</td>
<td>

Developmental concerns identified and discussed with caregivers. Start Developmental Referral Pathway.

</td>
</tr>
</table>

Record reason if Finished Incomplete: _____
_____
_____

* ASQ = Ages & Stages Questionnaire. ASQ-SE is the Social Emotional version.

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency**_____

Education Pathway

Initiation

Education Pathway started by (check only one):

☐ Program-based curriculum
☐ Client requests assistance
☐ Referral from health care provider
☐ Referral from other provider
☐ Community care coordinator initiated

_____
Start date

Document education provided

(Example: educational content—module, section, etc.)

_____
_____
_____
Education

Document educational format used (check only one).

Format:

☐ Handout
☐ Talking points
☐ Video
☐ Other:_____

Completion

Client reports that he/she understands educational information.

Record reason if Finished Incomplete: _____
_____
_____
_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Employment Pathway

Initiation Client is requesting assistance in obtaining a job.	_____ Start date _____ _____
Partner with client to identify: 1. Education and work history • Previous work experience • Educational level completed • Employment goals (special training needed for desired job) 2. Barriers to employment (felony record, financial constraints, etc.)	_____ Work history _____ Educational level _____ _____ _____ Employment goals _____ _____ Barriers
Care coordinator will work with client to confirm that résumé is completed.	_____ Date résumé completed
Care coordinator will work with client to monitor applications submitted for employment.	_____ _____ _____ _____ Dates applications submitted
Completion Client has found consistent source(s) of steady income and is employed over a period of 3 months.	_____ 1 month _____ 2 months _____ Completion—3 months _____ Check-in dates

Record reason if Finished Incomplete: _____

_____

_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Family Planning Pathway

Initiation Client has requested information on family planning methods.	_____ Start date
↓	
Provide family planning education.	Education provided ☐ Yes ☐ No
↓	
Schedule appointment with primary care provider or clinic	_____ Date of appointment _____ Provider or clinic
↓	
Followup with client Confirm that client kept appointment and document family planning method in chart. **Pathway is complete if tubal ligation, vasectomy, IUD, implant, or shot given.**	_____ Date appointment kept Family Planning Method ☐ Tubal Ligation (4) ☐ Vasectomy—partner (4)[i] ☐ IUD (4) ☐ Implant (4) ☐ Shot (4) ☐ Abstinence (5) ☐ Natural family planning (5) ☐ Pills (5) ☐ Patch (5) ☐ Ring (5) ☐ Diaphragm (5) ☐ Condom (5) ☐ Cervical cap (5) ☐ Spermicide (5) ☐ Other (5) _____
↓	
Completion If client has chosen a method other than tubal ligation, vasectomy, IUD, implant, or shot, then Pathway is complete if client is still successfully using that method after 30 days.	

Record reason if Finished Incomplete: _____
_____
_____

[i]The number 4 is a coding option; it is used for a permanent or long-acting reversible contraceptive. If these are chosen, the Pathway is finished once the procedure is complete. All the other methods ("5") are in a participant's control, and the Pathway is not finished until a followup check is done in 30 days to make sure she is still using the method chosen.

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Health Insurance Pathway

Initiation Client needs health insurance.	_____ Start date

$\downarrow$

Assist client and/or family in **completing forms** as directed and submit to appropriate agency.	_____ Date application submitted

$\downarrow$

Confirm with agency that all forms have been received and have been completed properly.	

$\downarrow$

Completion Arrange followup within 2-6 weeks of application submission to **confirm acceptance or denial** of insurance. • If **denied, record reasons** in client's record and refer client to other community resources. • If **accepted, document status**, including insurance number, in client's record.	_____ Date approved _____ Insurance _____ Number

Record reason if Finished Incomplete (reason denied and referral made):

_____
_____
_____
_____
_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Housing Pathway

Initiation	_____
Client and/or family is identified to be in need of affordable and suitable housing.	Start date

↓

Identify reason(s) housing is required: (check all that apply

❏ Eviction   ❏ Safety issue(s)
❏ Homeless   ❏ Too many for living space
❏ Domestic violence
❏ Lead   ❏ Financial
❏ Fire/natural disaster   ❏ Poor rental history
     ❏ Poor location for access to services
❏ Self-imposed (pets)
     ❏ Disability
❏ Discrimination   ❏ Other: _____

↓

Partner with client to contact appropriate housing organization and schedule an appointment to meet and discuss housing options.

Help client prepare for meeting with required documentation, child care, transportation, etc.

_____
Appointment scheduled

_____
Appointment kept

↓

Care coordinator confirms that client kept appointment with housing organization.

If client is placed on a waiting list for housing, obtain name and phone number of contact person to follow up with regarding status.

_____
Contact person

_____
Contact number

_____
_____
_____
_____

↓

Follow up with housing contact person at least biweekly to monitor housing progress.

Check-in dates

↓

Completion
Confirmation that client and/or family has moved into an affordable suitable housing unit for a minimum of 2 months.

_____
Completion date

Record reason if Finished Incomplete: _____
_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Immunization Referral Pathway

Initiation Client less than 18 years of age is confirmed to be behind on immunizations.	_____ Start date Missing Immunizations: _____ _____ _____ _____ _____ _____
Educate family about the importance of immunizations.	Education provided ☐ Yes ☐ No
Appointment(s) scheduled with provider or clinic for missed immunizations.	_____ _____ _____ Appointment dates _____ Completion date
Completion **Client's immunization record reviewed and verified to be up to date.**	_____ Reviewer

Record reason if Finished Incomplete: _____

_____

_____

_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Immunization Screening Pathway

Initiation Any client less than 18 years of age	_____ Start date
• Determine immunization status by using the family's immunization record. • If family is unable to provide records, obtain written consent from client's parents/guardians to request immunization record from provider(s).	Immunization History From: ☐ Family's record ☐ Electronic registry ☐ Health care provider ☐ Health department ☐ Other:_____
Educate family about the importance of immunizations and maintaining up-to-date record.	Education provided ☐ Yes ☐ No
Identify person trained in the current immunization protocols to review immunization status.	_____ Immunization records reviewer
Completion **Client's immunization record reviewed and verified.** 1. Client is up to date on all age-appropriate immunizations. Monitor immunization status during routine visits. Record Pathway as complete. 2. Client is not up to date on all age-appropriate immunizations. Record Pathway as Finished Incomplete. Document reasons immunizations are behind and start the Immunization Referral Pathway.	_____ Completion date ☐ Up to date ☐ Not up to date

Record reason if Finished Incomplete: _____

_____

_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Lead Pathway

Initiation Any child more than 12 months old and any child with identified risk factors (see step #4).	_____ Start date
↓	
Provide **lead education** to all families with young children and/or expectant mothers.	Education provided ☐ Yes ☐ No
↓	
Find out if child has ever had a blood lead test and document results.	_____ Results/date
↓	

Determine if child needs a blood lead test:
 	
1. Medicaid
 	
2. High-risk ZIP Code
 	
3. **"Yes"** to any of the following questions:
  • Live in or regularly visit a house, daycare center, preschool, or home of a babysitter/relative built before 1950?
  • Live in or visit a house that has peeling, chipping, dusting, or chalking paint?
  • Live in or visit a house built before 1978 with recent, ongoing, or planned renovation or remodeling?
  • Have a sibling or playmate who has or had lead poisoning?
  • Frequently come in contact with an adult who has a hobby or works with lead (e.g., construction, welding, pottery, painting)?
	Document all that apply:
	1. Medicaid
	  ☐ Yes ☐ No
	2. High-risk ZIP Code _____
	_____
	3. Yes to survey questions (circle)

↓	
Appointment scheduled with provider to do blood lead test.	_____ Appointment date
↓	Record reason if Finished Incomplete: _____
Completion **Confirm** that appointment was kept and **document results** of lead blood test in client's record as: ❖ Elevated: ≥ 10 µg/dl ❖ Nonelevated: < 10 µg/dl **Refer to Health Department**	_____ _____ _____ _____ _____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Medical Home Pathway

Initiation Client needs a medical home (an ongoing source of primary medical care).	_____ Start date
↓	
Determine payment source for health care.	Payment Source: ☐ Medicaid ☐ Medicare ☐ Private insurance ☐ Self-pay ☐ Other: _____ _____ _____
↓	
Find appropriate primary medical provider options for payment source.	_____ Medical provider
↓	
1. Obtain release of information from client. 2. Assist family in scheduling appointment. 3. Provide education about the importance of keeping the appointment.	_____ Date of initial appointment Education provided ☐ Yes ☐ No
↓	
Completion Confirm that appointment was kept.	_____ Date of kept appointment

Record reason if Finished Incomplete: _____

_____

_____

_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Medical Referral Pathway

Initiation Client needs a **health care appointment.** Document type of appointment needed – use codes. ***(Only ONE code per Pathway)***	_____ Start date _____ Referral - Code
↓	
Educate client/family about the importance of regular health care visits and keeping appointments.	Education provided ☐ Yes ☐ No
↓	
Appointment scheduled with health care provider/clinic.	_____ Appointment date
↓	
Completion **Verify** with health care provider that **appointment was kept**.	_____ Date appointment kept _____ Document how appointment was verified

Code Numbers for Medical Referral Pathway
1. Primary Care
2. Specialty Medical Care _____
3. Dental
4. Vision
5. Hearing
6. Family Planning
7. Mental Health
8. Substance Abuse
9. Speech and Language
10. Pharmacy
11. Other, please specify in record _____

Record reason if Finished Incomplete: _____
_____
_____

Client's Name _____ **Community Care Coordinator** _____

Date of Birth _____ **Today's Date** _____ **Agency** _____

Medication Assessment Chart

STEP 1:

☐ On the chart below, list all the medications **currently used** by your client. Include all medications – prescription, over the counter, herbal, alternative, topical, eye drops, etc.

☐ Have your client and/or client's caregiver **open each** of the bottles or medication containers and note any difficulties in performing this task.

☐ Have your client and/or client's caregiver **identify** each medication. Ask them to describe what the medicine is for. How many doses of the medicine are to be taken each day?

☐ Discuss the **shape and color** of the medicine with your client or client's caregiver. Explain that they should notify the health provider if the shape and color of the pill changes to make sure they are using the correct medicine and/or dose.

☐ Have the patient and/or client's caregiver read the medication name on the label. Assess reading and memory problems. Review all parts of the label, including how to order refills.

Prescription Medications (need a doctor's prescription to get)

Client's Name _____ **Community Care Coordinator** _____

Date of Birth _____ **Today's Date** _____ **Agency** _____

Name of Medicine & Dose	Can open? yes/no	What is this medicine for? (client's description)	How many doses each day? (client's response)	Can read the label and knows how to get refills? yes/no	Comments

Over the counter medicines (no prescription needed), herbal or alternative treatments

Name of Medicine or Treatment	Can open? yes / no	What is this medicine or treatment for? (client's description)	How many doses each day? (client's response)	Can read the label and knows how to get refills? yes/no	Comments

Client's Name _____ **Community Care Coordinator** _____

Date of Birth _____ **Today's Date** _____ **Agency** _____

STEP 2 - Ask the following questions:

1. Are you having problems getting your medications? ☐ Yes ☐ No

   If yes – why?

   _____
   _____

2. Do you have problems paying for your medications? ☐ Yes ☐ No

   If yes – what can you afford?

   _____
   _____

3. Are you having any side effects from your medications? ☐ Yes ☐ No

   If yes – describe:

   _____
   _____

4. Do you use more than one pharmacy to get your medications? ☐ Yes ☐ No

   If yes – please list all pharmacies:

   _____
   _____

Notes:

_____
_____

_____ _____
Provider Signature   Date

34

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

<div align="center">

Medication Assessment Pathway

</div>

Initiation Client is taking prescribed medication(s).	_____ Start date
Complete the **Medication Assessment Chart** with your client and/or client's caregiver: 1. Include all medications your client says he/she is taking right now (prescription, over the counter, herbal, alternative, etc.) 2. Record what your client says about the medication in his/her own words – even if it is different from the label.	
Send completed **Medication Assessment Chart** to client's primary care provider.	_____ Date information sent ☐ Fax ☐ HUB ☐ Mail ☐ Other_____
Completion **Verify** with primary care provider that chart was received. If medication issues are identified by health care provider – initiate Medication Management Pathway.	_____ Verification date Medication concerns: ☐ Yes ☐ No

Record reason if Finished Incomplete: _____
_____
_____
_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Medication Management Pathway

Initiation Client is not taking medications as prescribed. (Record referral source)	_____ Start date
↓	
Obtain list of medications client should be taking from: (check all that apply) ❒ Primary care provider ❒ Medication reconciliation form from hospital ❒ Medication reconciliation form from emergency department ❒ Pharmacist ❒ Other: _____	_____ _____ Referral source
↓	
Visit client in his/her home and complete the **Medication Assessment Chart:** 1. Send completed Medication Assessment Chart and any reconciliation forms to client's primary care provider. 2. Schedule appointment with primary care provider – record date.	_____ Date information sent ☐ Fax ☐ HUB ☐ Mail ☐ Other: _____ _____ _____ Scheduled appt. date
↓	
Primary care provider completes medication reconciliation: 1. Care coordinator receives updated medication list. 2. Home visit scheduled within 3 business days to follow up.	_____ Date appointment kept with primary care provider
↓	
Visit client in his/her home and complete the Medication Assessment Chart – send completed chart to primary care provider for review.	_____ Date information sent ☐ Fax ☐ HUB ☐ Mail ☐ Other: _____ _____
↓	
Completion **Verify** with primary care provider that client is taking medications as prescribed.	_____ Verification date

Record reason if Finished Incomplete: _____

_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Postpartum Pathway

Initiation
Client has delivered and needs to schedule a postpartum appointment.

_____
Start date

_____
Date of delivery

Schedule appointment with health care provider.

_____
Date of appointment

_____
Health care provider

Follow up with client:

1. Confirm that client kept appointment.
2. Document family planning method chosen in client's record.
3. Determine if client has any questions or concerns.

_____
Date postpartum appointment completed

_____
Family planning method

Record reason if Finished Incomplete: _____
_____
_____
_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Pregnancy Pathway

Initiation Any woman confirmed to be pregnant through a pregnancy test.	_____ Start date Education provided ☐ Yes ☐ No
↓	
Provide pregnancy education.	_____ Date of 1st PN appt. – set up by ☐ Client ☐ Care Coordinator
↓	
Schedule appointment with prenatal care provider: • Date of 1st prenatal appointment • Estimated due date • Concerns identified	_____ Prenatal care provider _____ Due date _____ _____ _____ Concerns
↓	
Check on woman's prenatal appointments at least monthly.	_____ _____ _____ _____ _____ _____ _____
↓	
Completion **Healthy baby > 5 lbs 8 ounces (2,500 grams).** Document baby's birth weight, estimated age in weeks, and any complications	_____ Date of birth _____ Birth weight _____ Gestational age (weeks)

Record reason if Finished Incomplete: _____

_____

_____

Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Smoking Cessation Pathway

Initiation Client states that he/she is a cigarette smoker/tobacco user.	_____ Start date
↓	

1. Determine where client is in the Stages of Change Model.
 	
2. **Develop and document care plan in record:**
   • Precontemplation: Educate and motivate at each visit.
   • Contemplation: Set a quit date and discuss withdrawal symptoms.
   • Action: Frequent support visits (especially the first 2 weeks after quitting), coping strategies, and self-help materials.
   • Maintenance: Continue to ask about client's smoking status at each visit; continue education and encouragement.
   • Relapse: Reassure client that most smokers take several attempts before finally quitting ⟶ set another quit date.
	_____
	Tobacco product
	
	_____
	Amount
	
	Stages of Change
	Model – check stage:
	☐ Precontemplation
	☐ Contemplation
	☐ Action
	☐ Maintenance
	☐ Relapse

↓	

For all clients - at EACH visit, stress the need to quit smoking:
• Discuss short- and long-term health, social, and economic benefits of quitting.
• Discuss and document any barriers identified.
• Discuss and document all options and refer if appropriate:
   – Self-help materials
   – Drug therapy
   – Smoking cessation programs	

↓	_____ Completion date
Completion Client has stopped smoking/using tobacco products.	☐ Self-report ☐ Lab test confirmation

Record reason if Finished Incomplete: _____

_____

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Client's Name _____ **Date of Birth** _____

Community Care Coordinator _____ **Agency** _____

Social Service Referral Pathway

Initiation Client needs a social service referral. Document type of service needed - use codes. *(Only ONE code per Pathway)*	_____ Start date _____ Code number Education provided ☐ Yes ☐ No
↓	
Provide appropriate education and discuss the importance of keeping appointments.	
↓	
Appointment scheduled with social service provider.	_____ Date of appointment
↓	
Completion Verify that client kept scheduled appointment.	_____ Date of kept appointment _____ Document how appt. was verified

Code Numbers for Type of Service

1. Child Assistance
2. Family Assistance
3. Food Assistance/WIC
4. Housing Assistance
5. Insurance Assistance
6. Financial Assistance
7. Medication Assistance
8. Transportation Assistance
9. Job/Employment Assistance
10. Education Assistance
11. Medical Debt Assistance
12. Legal Assistance
13. Parent Education Assistance
14. Domestic Violence Assistance
15. Clothing Assistance
16. Utilities Assistance
17. Translation Assistance
18. Help Me Grow
19. Other: _____

Record reason if Finished Incomplete: _____

_____

_____

_____

Appendix C. Sample Demographic and Referral Form

Richland Community HUB
Sample Demographic Form
Pregnant Client

Date: _____ Referred by: _____

Client's Name: _____

Address: _____

Phone:_____ Alternate Phone:_____

Client's Date of Birth: _____ Gender: M   F

Insurance Provider/Number:_____

Reason for Referral: _____

_____

_____

_____

Is Client Pregnant?   Y   N   Estimated Due Date: _____

Estimated Weeks: _____

Date of 1st Prenatal Visit: _____

Referral Received by: _____

Referral Assigned to:_____ on _____

Referral Outcome: _____

_____

_____

_____

_____

Appendix D: Sample Adult Checklist

Initial Adult Checklist

Visit Date: _____ Start: _____ End: _____ Visit Type: _____

Care Manager: _____

Name: _____ DOB: _____

Address: _____ Phone: _____

SSN: _____ Race: _____ Ethnicity: _____ Gender: ☐ M ☐ F

Insurance _____ Medicaid Number: _____

Referral Date: _____ Emergency Contact Number: _____

YES NO   Client Information

___ ___   **Are you single?**

If no: 1-significant other, 2-married, 3-separated, 4-divorced, 5-widowed, 6-other

_____

___ ___   **Do you rent your home or apartment?**
If no: 1-own home, 2-live with relatives, 3-live with friends, 4-not from this area,
5-homeless, 6-other _____

___ ___   **Do you speak another language besides English at home?**
If yes, do you need a translator for appointments? _____

___ ___   **Are you in school now?**
If no: 1-college graduate, 2-high school diploma, 3-GED, 4-dropped out of high school,
5-other_____

___ ___   **Are you interested in finding a job?**
If no: 1-employed, 2-on disability, 3-enrolled in a training program, 4-other_____

_____

If disabled, what is the reason? _____

___ ___   **Do you need help with transportation to appointments?**
What are you using now for transportation? _____

___ ___   **Do you have children?**
If yes: How many? _____

How many children live with you? _____

Do any of your children have special needs? _____

___ ___   **Do you need help with child care?**

___ ___   **Do you have any problems providing:**
1-housing, 2-food, 3-clothing, 4-utilities, 5-other?_____

___ ___   **Do you have any legal issues?**_____

YES NO   General Health

___ ___   **Do you need health insurance for yourself?**
            If no: Health insurance: _____

___ ___   **Do you need a family doctor?**
            If no: Family doctor's name _____

___ ___   **Do you need a dentist?**
            If no: Dentist's name _____

If you don't have a family doctor, where do you get your care?
1-ER, 2-Urgent Care, 3-Walk-in Clinic, 4-Other _____

Previous illnesses:_____
_____

Previous surgeries and hospitalizations:_____
_____

Allergies: _____
_____

YES NO   Current Medical Issues

___ ___   **Are you currently being treated for any of the following conditions?**
            1-infections, 2-asthma, 3-chronic medical conditions, 4-mental health conditions,
            5-mental retardation, 6-developmental disabilities or delays, 7-other: _____
            _____

___ ___   **Are you taking any medicines?**
            1-prescribed by your doctor, 2-over the counter, 3-herbal or alternatives, 4-other_____
            List all medications: _____
            _____

YES NO   Safety and Emotional Health

___ ___   Do you use tobacco products?
___ ___   Does anyone smoke in your home?
___ ___   Do you drink alcohol?
___ ___   Do you use other substances?
___ ___   Are you stressed?
___ ___   Are you feeling depressed?
___ ___   Have you experienced emotional, verbal, or physical abuse?
___ ___   Do you have a working smoke detector?
___ ___   Are there any safety concerns in the home?
            Describe: _____
___ ___   Is there a gun in the home? If yes, is the gun locked? Yes___ No___
___ ___   Are there any pets in the home?
___ ___   *If children at home, ask:* Do you read to your child(ren)?
            If yes, how often?_____

List all other agencies that you are working with now:

_____
_____
_____
_____
_____

NOTES

_____
_____
_____
_____

Please add the following Pathway(s): (Represents the request from the care coordination agency to the HUB to add pathways to the Care Coordination Plan and tracking. List of Pathways here represents local set.

__ Adult Education
__ Chemical Dependency
__ Depression
__ Employment
__ Family Planning
__ Family Violence
__ Health Insurance
__ Immunization Screening
__ Immunization Referral
__ Lead
__ Medical Referral _____
__ Medication Assessment
__ Medication Management
__ Pregnancy
__ Postpartum
__ Smoking Cessation
__ Social Service Referral _____
__ Suitable Housing
__ Other: _____

_____

Next home visit date: _____